

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05160									
1. PLACE OF DEATH a. COUNTY		Baltimore		5186		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		1Y.10M. 3D.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Sheppard Pratt							
3. NAME OF DECEASED (Type or print)		First NANCY		Middle ANN		Last ABELL		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White				4/27/1934		25 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
none				Washington, D. C.		U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Capt. Harry Sanderson Abell				Elizabeth Marie Palmer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
						Mother - 924 25th. St., N.W., Wash. 7, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 308.1 Central nervous system convulsive disorder									
DUE TO (b) _____									
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				5/23/59	
William V. Lovitt, Jr., M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		5/27/59		Arlington National Cem.		Fort Myer.		Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Joseph F. Dwyer Sons				3034 M St., N.W. WASH. D.C.		MAY 27 '59		Arthur L. Kenna	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5187

CERTIFICATE OF DEATH

Reg. Dist. No.

05161

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 51 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wayne Nursing Home, 98 Smithwood Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 414 Lyndhurst St							
3. NAME OF DECEASED (Type or print) Herman Ahlers				4. DATE OF DEATH May 7/59			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1889	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Geo. Becker Lumber Co. Germany			
11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME late Herman Ahlers				14. MOTHER'S MAIDEN NAME late Christine Ahlers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214 12 0515			
17. INFORMANT Miss Elizabeth S. Ahlers, 414 Lyndhurst St				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Congestive Heart Failure DUE TO (b) Acute & Chronic DUE TO (c) Degenerative Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) with Atrial Fibrillation, Cardiac Enlargement & Edema							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 58 to 7 May 59 , that I last saw the deceased alive on 7 May 59 , and that death occurred at 2:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. McGloth				DATE SIGNED 5/7/59			
PHYSICIAN'S NAME (Type) W. E. McGloth				ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 9/59			
22c. NAME OF CEMETERY OR CREMATORY New Cathedral				22d. LOCATION (City, town, or county) (State) Baltimore 29 Md			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave				24a. REC'D BY REGISTRAR MAY 8 '59			
ADDRESS				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG242 5-19-59 et

05162

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5188 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b Tarrytown 69x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 29 Warren Avenue	
3. NAME OF DECEASED (Type or print) First CLAIRE Middle CAHILL Last ALEXANDER		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1912
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Manager	
11. BIRTHPLACE (State or foreign country) Dayton, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John L. Alexander		14. MOTHER'S MAIDEN NAME Florence E. Early	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 538-24-6927	
17. INFORMANT Vanderbilt Funeral Home, Tarrytown, N.Y.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 Hour PM 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	20f. (City or town) (County) (State) Chase Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		DATE SIGNED 7/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 5-14-59	22c. NAME OF CEMETERY OR CREMATORY Sleepy Hollow Cemetery	22d. LOCATION (City, town, or county) (State) Tarrytown, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAY 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kenna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Education 30(6)

5189

CERTIFICATE OF DEATH

Reg. Dist. No.

05163

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 34</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City - 34</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1319 Hillsway Ct.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Ambrose</u> Last <u>Ambrose</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>02</u> Days <u>02</u> Hours <u>00</u> Min. <u>00</u>	11. IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>@ home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Nigro</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Leo Ambrose 1319 Hillsway Ct.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) <u>Arterio hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/15</u> , 19 <u>57</u> , to <u>5/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/5</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon Grau</u>		ADDRESS (Street, city or town, state) <u>8523 Frost Raven Bldg 36/59</u>	
PHYSICIAN'S NAME (Type) <u>GORDON GRAU MD</u>		DATE SIGNED <u>5/6/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>5/9/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town or county) (State) <u>Bald Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.J. Ruck, Inc. 5305 Hartford Rd. #14</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thayer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• 1980-1981 •

4267 3 105

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **05164**

5190

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2321 Birch Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First IRENE Middle E. Last ARING		4. DATE OF DEATH		Month May Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1894		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John F. Dorr				14. MOTHER'S MAIDEN NAME Christina Washenfeldt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Walter J. Aring, Sr - 2321 Birch Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Liver metastases							
INTERVAL BETWEEN ONSET AND DEATH 8 hours							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 1957 to May 23rd 1959 , that I last saw the deceased alive on May 11, 1959 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, State) 4710 Liberty St. Balto DATE SIGNED May 27 '59							
ACTUAL SIGNATURE E. J. VOLENICK M.D.		PHYSICIAN'S NAME (Type) E. J. VOLENICK MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.				24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Christina & Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DO NOT WRITE IN THESE SPACES
FOR CONTENT

MEMORANDUM
JAN 14 1964

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]	
2. SEX [Faint text]	
3. AGE [Faint text]	
4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]	
8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]	
11. DATE OF DEATH [Faint text]	
12. PLACE OF DEATH [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]	
14. SIGNATURE OF DECEASED [Faint text]	

CERTIFICATE OF DEATH

Reg. Dist. No.

05165

5191

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 Frederick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE WILSON ATKINS		4. DATE OF DEATH May 26, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-5229	
17. INFORMANT Mrs. Esther Strecker, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis Acute DUE TO Coronary thrombosis with posterior Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. infarction old + 3rd Degree DUE TO Heart Block PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart Block		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 12, 1959 , that I last saw the deceased alive on 12 May 1959 and that death occurred at 4:00 PM , from the causes and on the date stated above.		21. ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md DATE SIGNED 5/27/59	
ACTUAL SIGNATURE W. E. Mc Grath M.D.		22. LOCATION (City, town, or county) (State) Ellicott City, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-59	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. REGISTRAR'S SIGNATURE Arthur S. Kneass	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR JUN 1 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05163

CERTIFICATE OF DEATH

1952

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]

10. Name of informant: [illegible]
11. Address of informant: [illegible]
12. Signature of informant: [illegible]

W E Mc Graw
1303 Franklin St
Cottamville, Mo
Aug 1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05166

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore 5192 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 34yr27dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1735 East Baltimore Street			
3. NAME OF DECEASED (Type or print) First Binnie Middle Auerbach Last				4. DATE OF DEATH Month May Day 7 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1901		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY upholstery factory		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Berish Aberbuch				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis with hypertension (c) Arteriosclerosis with hypertension DUE TO cause lost.</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>George M. Kieffer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-14-59	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-59		22c. NAME OF CEMETERY OR CREMATORY Ches. Sholom		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Mc</i>				ADDRESS 2100 Eutar Place		24a. REC'D BY REGISTRAR DATE MAY 15 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

15166

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
HEALTH DEPT.

1883

1883
JAN 10
1883

Form with multiple sections for medical examination, including fields for name, age, sex, occupation, and cause of death. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]
AGE: [Handwritten Age]
SEX: [Handwritten Sex]
OCCUPATION: [Handwritten Occupation]
CAUSE OF DEATH: [Handwritten Cause of Death]

5153

CERTIFICATE OF DEATH

05187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 123 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle P. Last BACKMAN		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Transit Company	
11. BIRTHPLACE (State or foreign country) Ft. Wayne, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Backman		14. MOTHER'S MAIDEN NAME Mary Marrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes SAW		16. SOCIAL SECURITY NO. 213-10-1134	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 9, 1959 to May 12, 1959 and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 5/12/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Tickner & Sons, Inc. North & Penna. Aves.		24a. REC'D BY REGISTRAR MAY 13 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5194

Item 9 Film G242 5-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05168

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks			c. LENGTH OF STAY IN 1b 11fe	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belfast Rd.				d. STREET ADDRESS Belfast Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna M. Bacon				4. DATE OF DEATH Month Day Year 5-1-59 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1888		9. AGE (In years last birthday) 71 7/10 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Court		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis M. Bacon				14. MOTHER'S MAIDEN NAME Anna Dosh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-20-9790		17. INFORMANT self			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Ovary with multiple metastasis 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/7 , 19 59 , 5/1 , 19 59 , that I last saw the deceased alive on 5/1 , 19 59 , and that death occurred at 1.10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) York Rd., Parkton P.O. Hereford, Md. DATE SIGNED 5/2/59							
ACTUAL SIGNATURE C. Herbert Mueller Jr.				PHYSICIAN'S NAME (Type) C. Herbert Mueller Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-59		22c. NAME OF CEMETERY OR CREMATORY Monkton Methodist		22d. LOCATION (City, town, or county) (State) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brook				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05168

CENTRAL OF DEATH

1918

Baltimore

Baltimore

Baltimore

Baltimore

Life

Sparks

Baltimore Md.

Baltimore Md.

2-1-22

E. Bacon

Anna

2-1-1888

White

Female

U.S.A.

Baltimore Co. Court Maryland

Clark

Anna Dean

Lewis M. Bacon

Baltimore

217-20-222

No

Baltimore

2-1-22

Baltimore

Baltimore

2-1-22

Baltimore

5195

CERTIFICATE OF DEATH

05169

Reg. Dist. No.

1. PLACE OF DEATH Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Baltimore		MARYLAND		a. STATE Maryland		b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 3617 Forest Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Lola		Middle Sue		Last Baer		Month 5 Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/7/38		9. AGE (In years last birthday) 20 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Curtis Watson Baer				14. MOTHER'S MAIDEN NAME Eleanor Ridgely Dew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia with acute bronchitis and inanition 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Spastic Quadriplegia with athetosis (c) INTERVAL BETWEEN ONSET AND DEATH 4/23/59 Birth							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/23/59 , 19____, to 5/5/59 , 19____, that I last saw the deceased alive on 5/5/59 , 19____, and that death occurred at 9:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rosewood State Training School DATE SIGNED 5/5/59							
ACTUAL SIGNATURE Harry G. Butler		M.D. Rosewood State Training School					
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/1959		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600				ADDRESS Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR MAY 7 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5168

CERTIFICATE OF DEATH

05170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. LENGTH OF STAY IN 1b X Baltimore 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6409 Blenheim Road				d. STREET ADDRESS 6409 Blenheim Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATIE Middle LEE Last BARTHOLOMAE				4. DATE OF DEATH Month May Day 30 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Engelhardt				14. MOTHER'S MAIDEN NAME Della Harden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Mrs. Howard E. Dallam, 6409 Blenheim Rd., Balto.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) CARCINOMA BREAST DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 Mos 4 Mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10, 1948 , to May 30, 1959 , that I last saw the deceased alive on May 25, 1959 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6100 YORK RD BALTO-12 MD 6/1/59							
ACTUAL SIGNATURE Frederick J. Vollmer		M.D. 6100 YORK RD BALTO-12 MD 6/1/59					
PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE JUN 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove death papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Date of burial

9. Place of burial

10. Signature of registrar

11. Name of informant

12. Signature of informant

13. Name of registrar

14. Signature of registrar

15. Name of registrar

16. Signature of registrar

17. Name of registrar

18. Signature of registrar

19. Name of registrar

20. Signature of registrar

21. Name of registrar

22. Signature of registrar

23. Name of registrar

24. Signature of registrar

25. Name of registrar

26. Signature of registrar

27. Name of registrar

28. Signature of registrar

29. Name of registrar

30. Signature of registrar

31. Name of registrar

32. Signature of registrar

33. Name of registrar

34. Signature of registrar

b. COUNTY Balto.

54 Essex

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

You

Hours

USA

Laura Spellman

Mr. Irvin Batson, 327 Wye Rd., Essex Md.

INTERVAL BETWEEN ONSET AND DEATH

{c}

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

(State)

DATE SIGNED
5/2/59

Only 21 md

(State)

24b REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

1918

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5197

CERTIFICATE OF DEATH

Reg. Dist. No. 05172

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3502 Chapman Road		d. STREET ADDRESS 3502 Chapman Road	
3. NAME OF DECEASED (Type or print) First ETHEL Middle JOHNSON Last BELCHER		4. DATE OF DEATH Month May Day 29 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1882
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Winchester, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James K. P. Johnson		14. MOTHER'S MAIDEN NAME Rosalind Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas Town Belcher-3502 Chapman Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 5/10/59 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction 5/29/59 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks + 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 10 , 19 59 , to MAY 29 , 19 59 , that I last saw the deceased alive on MAY 29 , 19 59 , and that death occurred at 11 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler M.D.		ADDRESS (Street, city or town, state) 3601 Clifmar Rd - 7 DATE SIGNED 5/30/59	
PHYSICIAN'S NAME (Type) Thomas E. Wheeler, M.D.		3601 Clifmar Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/1959	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Mausoleum		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR JUN 2 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6243 6-2-59 et

5198

CERTIFICATE OF DEATH

05173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 6717 Queens Ferry Rd. Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE MONTGOMERY b. COUNTY 24 Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENDALE		c. LENGTH OF STAY IN 1b 2 mons.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jean C. Benton		4. DATE OF DEATH Month May Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1908
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Constantine Nasuro		14. MOTHER'S MAIDEN NAME Stella Sobush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-4697	
17. INFORMANT William J. Benton		Address MONTGOMERY 14 N. Milton Ave. 24	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x Pulmonary Insufficiency DUE TO (b) Cerebral infarction DUE TO (c) accident left heart			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/12 , 19 59 , to 5/21 , 19 59 , that I last saw the deceased alive on 5/21 , 19 59 , and that death occurred at 9:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Grow M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 2 E. Reed St (2)	
PHYSICIAN'S NAME (Type) JOHN L. GROW M.D.		2 E. Reed St (2)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25, 1959	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 1 M 014 1 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5199 CERTIFICATE OF DEATH

Reg. Dist. No.

05174

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4yr 11mth 8dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion DeWolf				4. DATE OF DEATH May 27 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1891	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife Mgr. Rtd.				10b. KIND OF BUSINESS OR INDUSTRY Carlins Park		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John DeWolf				14. MOTHER'S MAIDEN NAME Margaret Cartwright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 124-12-7522		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year May 20 19 59 Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I attended the deceased from May 20 , 19 59 , to May 27 , 19 59 , that I last saw the deceased alive on May 27 , 19 59 , and that death occurred at 6:00a M, from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-27-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt				24a. REC'D BY REGISTRAR JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10114

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1895		BALTIMORE, MD.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
Carpenter		High School		Married		Roman Catholic		White	
Usual Residence		Place of Death		Cause of Death		Manner of Death		Physician	
1234 E. Main St.		1234 E. Main St.		Heart Disease		Natural		Dr. J. H. Smith	
Date of Death		Time of Death		Hour of Death		Day of Death		Month of Death	
JUN 10 1940		10:30 AM		10:30		JUN 10		JUN 1940	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05175									
1. PLACE OF DEATH a. COUNTY BALTIMORE		5200		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 3111 Northway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANCY PEARL BILLUPS				4. DATE OF DEATH Month May Day 30th Year 19 59					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1899		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Gillogly				14. MOTHER'S MAIDEN NAME Minnie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nancy Haynes, 29 Riverside Road, #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning. Found Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found Drowned							
20c. TIME OF INJURY Hour XXX p. m. 5/30/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bird River		20f. (City or town) Baltimore		20g. (County) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .									
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-31-59			
EXAMINER'S NAME (Type) PAUL F. GUERIN				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/59		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G242 5-11-59 et
5261 CERTIFICATE OF DEATH

Reg. Dist. No.

05176

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Rolling Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) R. Howard Bland		4. DATE OF DEATH Month 5 Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Bland		14. MOTHER'S MAIDEN NAME Maria Hardin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John R. Bland, II		Address Rolling Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c) Pulmonary Fibrosis			INTERVAL BETWEEN ONSET AND DEATH 4 hr 2 years 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 57 , to May 2 , 19 59 , that I last saw the deceased alive on May 1 , 19 59 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Mears		ADDRESS (Street, city or town, state) DATE SIGNED 1118 St. Paul St. - Baltimore 2 Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/5/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Mears and Son		ADDRESS 805 N. Calvert St. - 2	
24a. REC'D BY REGISTRAR MAY 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05177**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5202 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Old Greenwich 45X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 14 Crossbridge Road			
3. NAME OF DECEASED (Type or print) First LESLIE Middle Greene Last Jr. BOATRIGHT				4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1924		9. AGE (in years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leslie G. Boatright				14. MOTHER'S MAIDEN NAME Nellie Walter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Campbell-Louis Fun'l Home, Marshall, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis, M.D.				DATE SIGNED 5/12/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/14/59		22c. NAME OF CEMETERY OR CREMATORY Marshall Cemetery		22d. LOCATION (City, town, or county) (State) Marshall, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

1

STATE OF TEXAS
COUNTY OF DALLAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68		10:00 PM	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		POSTMORTEM EXAMINATION	
Dallas, Texas		Suicide by gunshot		Homicide		No apparent disease or injury		No significant medical history		No significant postmortem findings	
PLACE OF BURIAL		DATE OF BURIAL		NAME OF BURIAL PLACE		NAME OF MINISTER		NAME OF WITNESSES		NAME OF CORONER	
Dallas, Texas		4/4/68		Oakwood Cemetery		Rev. J. B. Smith		John Doe, Jane Doe		John Doe	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF DENTIST		NAME OF NURSE		NAME OF MIDWIFE		NAME OF OTHER	
None		None		None		None		None		None	
NAME OF EXAMINER		NAME OF ASSISTANT		NAME OF CLERK		NAME OF RECORDER		NAME OF FILE CLERK		NAME OF OTHER	
John Doe		Jane Doe		John Doe		Jane Doe		John Doe		Jane Doe	

05178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 06 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor		d. STREET ADDRESS Liberty Lake Drive	
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE TERESA BOPP		4. DATE OF DEATH Month Day Year May 18 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Weltner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Margaret A. Bopp-Liberty Lake Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. disease & Renal DUE TO (c) Failure - severe INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL - 1949 , to MAY 18 1959 , that I last saw the deceased alive on MAY 18 1959 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler M.D.		ADDRESS (Street, city or town, state) 3601 Clifmar Rd - Balt 9 - 519/59 DATE SIGNED	
PHYSICIAN'S NAME (Type) Thomas E. Wheeler, M.D.		3601 Clifmar Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/1959	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR DATE MAY 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Fiance			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
2885 - CERTIFICATE OF DEATH

PLACE IN CASE	
DECEASED	
RESIDENCE	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
AGE	
SEX	
RACE	
BIRTH DATE	
BIRTH PLACE	
MARRIAGE DATE	
MARRIAGE PLACE	
PREVIOUS MARRIAGES	
EDUCATION	
OCCUPATION	
RELIGION	
SIGNED AND SEALED	
DATE	
PLACE	
SIGNATURE	
TITLE	
OFFICE	
COUNTY	
STATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

 #12
05179

1. PLACE OF DEATH a. COUNTY Baltimore 5264 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Rhode Island b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick 76 x - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 75 Flagg Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First JEAN		Middle Donald		Last BOUCHARD	
4. DATE OF DEATH		Month May		Day 12,		Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1923		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Rep.		10b. KIND OF BUSINESS OR INDUSTRY I.C.A.		11. BIRTHPLACE (State or foreign country) Pittsfield, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Don R. Bouchard				14. MOTHER'S MAIDEN NAME Annette M. Rieley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11		17. INFORMANT Barry-Holdridge Funeral Home, Cranston, Rhode Island			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Hour 5:15 p. m. Month, Day, Year 5/12 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis		EXAMINER'S NAME (Type) M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery		22d. LOCATION (City, town, or county) (State) Cranston, Rhode Island	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5205 CERTIFICATE OF DEATH

Reg. Dist. No.

05180

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3649 CORONADO RD.</u>		d. STREET ADDRESS <u>924 HOMESTEAD ST.</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First Middle Last <u>A. BOWERS</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD MAC CUBBIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-10-2949</u>	
17. INFORMANT <u>MR. HARVEY KENNETH HUGHES</u>		Address <u>924 HOMESTEAD ST BALTO.-18</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HAS CVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Diameter mellitus</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>23 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>23 May</u> , 19 <u>59</u> , and that death occurred at <u>5:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel Bakal</u>		ADDRESS (Street, city or town, state) <u>3600 Lochearn Dr. - 7</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL BAKAL, M.D.</u>		DATE SIGNED <u>5/25/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-27-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM. PK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Walter Conklin</u>		ADDRESS <u>5444 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

CERTIFICATE OF DEATH

10-10-18

See Day 10

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

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CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05181

5206

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 104 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 501 West University Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First A.		Middle BRADY		Last	
4. DATE OF DEATH May		Month 12		Day 1959		Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1894		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile Agency		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles H. Brady				14. MOTHER'S MAIDEN NAME Etta O'Neil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO.		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS OF LIVER 581.1 X66X6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MULTIPLE ABSCESSSES OF KIDNEYS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 YEARS 2 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 3 , 19 59 , to May 12 , 19 59 , and that death occurred at 11:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 5/13/59 ACTUAL SIGNATURE Wm. Cook-Bligh M.D. Director, Professional Services PHYSICIAN'S NAME (Type) Wm. Cook-Bligh M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National C.M.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Bligh, Inc. 6009 Harford Rd., Balto. Md.				24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4200

Reg. Dist. No. 05182

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonelaugh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonelaugh</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1710 Regeester Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMILY HELEN BREARLEY</u>		4. DATE OF DEATH <u>May 19 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn Valley Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry C Dickel</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mc Gruder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Irene B Parker</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensative Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12 1949</u> to <u>May 19 1959</u> , that I last saw the deceased alive on <u>May 19 1959</u> and that death occurred at <u>8 A M</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		M.D. <u>6805 York Rd.</u> DATE SIGNED <u>5/19/59</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>		<u>Baltimore 12 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>May 21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Southern Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Miami Fla</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Jenkins</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>MAY 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

2207 CERTIFICATE OF DEATH

UNIQUE IDENTIFICATION NUMBER

DATE OF BIRTH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF WITNESS		NAME OF DECEASED	
ADDRESS OF PHYSICIAN		ADDRESS OF WITNESS		ADDRESS OF DECEASED	
CITY OF PHYSICIAN		CITY OF WITNESS		CITY OF DECEASED	
STATE OF PHYSICIAN		STATE OF WITNESS		STATE OF DECEASED	
COUNTRY OF PHYSICIAN		COUNTRY OF WITNESS		COUNTRY OF DECEASED	
OCCUPATION OF PHYSICIAN		OCCUPATION OF WITNESS		OCCUPATION OF DECEASED	
EDUCATION OF PHYSICIAN		EDUCATION OF WITNESS		EDUCATION OF DECEASED	
RELIGION OF PHYSICIAN		RELIGION OF WITNESS		RELIGION OF DECEASED	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF WITNESS		NAME OF DECEASED	
ADDRESS OF PHYSICIAN		ADDRESS OF WITNESS		ADDRESS OF DECEASED	
CITY OF PHYSICIAN		CITY OF WITNESS		CITY OF DECEASED	
STATE OF PHYSICIAN		STATE OF WITNESS		STATE OF DECEASED	
COUNTRY OF PHYSICIAN		COUNTRY OF WITNESS		COUNTRY OF DECEASED	
OCCUPATION OF PHYSICIAN		OCCUPATION OF WITNESS		OCCUPATION OF DECEASED	
EDUCATION OF PHYSICIAN		EDUCATION OF WITNESS		EDUCATION OF DECEASED	
RELIGION OF PHYSICIAN		RELIGION OF WITNESS		RELIGION OF DECEASED	



RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 5208 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9113 Hines Road				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 9113 Hines Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First WALTER Middle WILMER Last BREWER				4. DATE OF DEATH Month May Day 25 Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1907		9. AGE (In years last birthday) 57 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Brewer				14. MOTHER'S MAIDEN NAME Charlotte Gildenferney									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Joseph A. Brewer, Sr. Address same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage 541.0 DUE TO bleeding ulcer of duodenum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Partial			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 5/26/59				
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/28/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.				22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck						ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR MAY 28 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CITY OF DEATH [Illegible]	
COUNTY OF DEATH [Illegible]		STATE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]			
MANNER OF DEATH [Illegible]			
SIGNATURE OF EXAMINER [Illegible]			
OFFICE OF THE MEDICAL EXAMINER [Illegible]			
DATE OF EXAMINATION [Illegible]			
TIME OF EXAMINATION [Illegible]			
PLACE OF EXAMINATION [Illegible]			
CITY OF EXAMINATION [Illegible]			
COUNTY OF EXAMINATION [Illegible]			
STATE OF EXAMINATION [Illegible]			
SIGNATURE OF DECEASED [Illegible]			
DATE OF SIGNATURE [Illegible]			
TIME OF SIGNATURE [Illegible]			
PLACE OF SIGNATURE [Illegible]			
CITY OF SIGNATURE [Illegible]			
COUNTY OF SIGNATURE [Illegible]			
STATE OF SIGNATURE [Illegible]			
SIGNATURE OF WITNESS [Illegible]			
DATE OF SIGNATURE [Illegible]			
TIME OF SIGNATURE [Illegible]			
PLACE OF SIGNATURE [Illegible]			
CITY OF SIGNATURE [Illegible]			
COUNTY OF SIGNATURE [Illegible]			
STATE OF SIGNATURE [Illegible]			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9, Film G-243 6/1/59.cac.

Reg. Dist. No. 05184

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5269 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE GEORGIA b. COUNTY Atlanta 49x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b 49x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 2121 McKinley Rd., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Lee BROPHY		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894 June 25, 1895
9. AGE (in years last birthday) 64 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer Owner		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME J. M. Brophy		14. MOTHER'S MAIDEN NAME Martha Wilcox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes World War 1		16. SOCIAL SECURITY NO. 255-03-2164	
17. INFORMANT Mrs. Nell W. Brophy - 2121 McKinley Rd., N. W.		Address Atlanta, Ga.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 19 59 Hour 5:15 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	20f. (City or town) (County) (State) Chase Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 5/13/59	22c. NAME OF CEMETERY OR CREMATORY Bay Spring	22d. LOCATION (City, town, or county) (State) Rhine, Ga.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
ADDRESS 17 Ind		24b. REGISTRAR'S SIGNATURE Arthur B. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5210

Item 4, File G-243 5/26/59.cac

CERTIFICATE OF DEATH

05185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 14 Haddington Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last BROWN		4. DATE OF DEATH Month May Day 15 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1877
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired motorman		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brown		14. MOTHER'S MAIDEN NAME Mary Manning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rita Altevogt-14 Haddington Rd. Lutherville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15 , 19 59 , to 5/15 , 19 59 , that I last saw the deceased alive on 5/15 , 19 59 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post		ADDRESS (Street, city or town, state) 6805 York Rd Baltimore Md	
DATE SIGNED May 18 59			
PHYSICIAN'S NAME (Type) LAURENCE C. POST			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19/1959	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		24a. REC'D BY REGISTRAR May 18 59	
ADDRESS 1050 York Rd. Towson		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

05183

CERTIFICATE OF DEATH

1910

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Date of Birth

Date of Death

Place of Birth

Place of Death

Cause of Death

Manner of Death

Date of Burial

Age at Death

Place of Burial

Name of Burial Place

Sex

Race

Religion

Marital Status

Occupation

Education

Date of Birth

Date of Death

Date of Burial

Date of Interment

Date of Cremation

Date of Dissection

Date of Autopsy

Date of Birth

Date of Death

Date of Burial

Date of Interment

Date of Cremation

Date of Dissection

Date of Autopsy

Date of Birth

Date of Death

Date of Burial

Date of Interment

Date of Cremation

Date of Dissection

Date of Autopsy

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Date of Death

Date of Burial

Date of Interment

Date of Cremation

Date of Dissection

Date of Autopsy

Date of Birth

Date of Death

Date of Burial

Date of Interment

Date of Cremation

Date of Dissection

Date of Autopsy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5211

CERTIFICATE OF DEATH

05186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 339 Stafford Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harriet G. Brown		4. DATE OF DEATH 5/9/59	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1906	
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME Mary A. Gales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Margaret Hilgartner, 339 Stafford Dr.	
16. SOCIAL SECURITY NO. 577 54 1943		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170X DUE TO (c) 1 yr. INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 4, 1959 , to May 9, 1959 , that I last saw the deceased alive on May 4, 1959 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6614 Edmondson Ave Baltimore, Md. DATE SIGNED MAY 11/59 ACTUAL SIGNATURE J. Nelson McKay M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave		24a. REC'D BY REGISTRAR MAY 13 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

02185

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

Baltimore

Md.

Baltimore

Catonville

Catonville

339 Stafford Drive

389 Stafford Drive

Harriet G. Brown

2/9/59

Female

White

X

Nov. 1, 1906

25

Domestic

England

England

William Brown

Mary A. Gales

577 24 1943 Margaret Hightower, 339 Stafford Dr.

Burial London Park

2/12/59

Burial

Baltimore, Md.

Howard H. Hubbard #107 Wilkens Ave

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9, Film G-243 5/26/59 cac

05187

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore 5212 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. LENGTH OF STAY IN 1b 54 Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Co., Plant 2, Paint Hanger		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES O. Middle BUCHANAN Last 		4. DATE OF DEATH Month May Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1916 Sept. 22, 1915
9. AGE (in years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Urie L. Buchanan		14. MOTHER'S MAIDEN NAME Emma Connolly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-16-9961	
17. INFORMANT Otis Buchanan		Address 827 Dorsey Ave. #21	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd + 4th Burn now extensive 916.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Burn in Epinephrine		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Voluntary pleural emphysema	
20c. TIME OF INJURY Month, Day, Year 5-20-59		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Martin Co Middle River-Baltimore Md		20f. (City or town) (County) (State) Middle River-Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M B Davis		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski		ADDRESS 1407 Eastern Ave	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

05187

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1818

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is heavily obscured by faint, illegible markings and bleed-through from the reverse side.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5213

CERTIFICATE OF DEATH

Reg. Dist. No.

05188

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3641 Forest Garden Ave.</u>				e. STREET ADDRESS <u>4302 Garrison Blvd</u>			
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>P.</u> Last <u>Buckantz</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1908</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isadore Cohen</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Colore Sachs-3641 Forest Garden Ave</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>420.1</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis Right hemiplegia</u> DUE TO <u>arteriosclerosis</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>10 yrs</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhage from gastric ulcer</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> , 19 <u>59</u> to <u>5/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/7</u> , 19 <u>59</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton B. Kirsh</u>		M.D. <u>2320 Sutow Pl</u>		ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u>		DATE SIGNED <u>5/11/59</u>	
18. NAME (Type) <u>Milton B. Kirsh, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friends</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Feinman & Son</u> ADDRESS <u>1124-26 W. North Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. Jones</u>	

5214

CERTIFICATE OF DEATH

05189

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>55</u> <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>245 Linden Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>L.</u> Middle <u>BUCY</u> Last				4. DATE OF DEATH <u>May 5, 1959</u> Month <u>May</u> Day <u>5</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Galm</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Guest</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Roy Kroh, 245 Linden Ave., Towson 4, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio vascular disease -</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } (b) <u>cardiac infarction</u> DUE TO <u>Edema of Lungs</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>1 yrs</u> <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 24, 1959</u> to <u>May 5, 1959</u> , that I last saw the deceased alive on <u>May 5, 1959</u> , and that death occurred at <u>2:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>6, 8, 1959</u>				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>May 6/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Koons</u>				<u>601 Biddle St. Baltimore, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		Heart Disease		Natural		JAN 20 1945		BALTIMORE, MD	
MARITAL STATUS		EDUCATION		RELIGION		SIGNED BY		TITLE		DATE	
Married		High School		Roman Catholic		J. H. HARRIS		Physician		JAN 20 1945	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE	
None		JAN 15 1945		JAN 20 1945		JAN 22 1945		CATHOLIC CHURCH		JAN 22 1945	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYPERSON		SIGNATURE OF REGISTRAR		DATE	
				J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		JAN 20 1945	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05190

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 1006 Overbrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) KENNETH D. BURNHAM, SR.		4. DATE OF DEATH Month May Day 11 Year 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1897		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William D. Burnham						14. MOTHER'S MAIDEN NAME Annie Keller													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWI				16. SOCIAL SECURITY NO. 705-09-8121				17. INFORMANT Mrs. Anne Kelly-1006 Overbrook Rd-12				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Coronary Occlusion DUE TO Hypertensive Cardio-renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Vascular Dis (b) 7 yr (c) 7 yr																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>																			
ACTUAL SIGNATURE Charles F. O'Donnell				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) Charles F. O'Donnell				DATE SIGNED 5/14/59															
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial				22b. DATE THEREOF 5/14/59				22c. NAME OF CEMETERY OR CREMATORY Prospect Hill				22d. LOCATION (City, town, or county) (State) Towson, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. Towson 4, Maryland								ADDRESS				24a. REC'D BY REGISTRAR May 14 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5216
1, 11, 12 Film 6242 5-18-59 et
CERTIFICATE OF DEATH

05191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1515 Edmondson Ave. "Residence"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>H. S.</u> Last <u>CAKE</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd. Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob F. Cake</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Letitia Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Mr. Lawrence Cake-1001 Conn. Ave., Wash., D. C.</u>	
17. INFORMANT <u>Mr. Lawrence Cake-1001 Conn. Ave., Wash., D. C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure & Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/21</u> , 19 <u>57</u> , to <u>5/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>59</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1515 Edmondson Ave. Balt.</u> DATE SIGNED <u>5/12/59</u>			
ACTUAL SIGNATURE <u>Cliff Ratliff</u>		M.D. <u>1515 Edmondson Ave. Balt.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>BALTIMORE 29. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balt.</u>		ADDRESS <u>17 Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05192

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5217 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Green c. LENGTH OF STAY IN 1b X d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Valley Road, Glenarm P.O.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Green d. STREET ADDRESS Dulaney Valley Road, Glenarm, P.O. e. IS RESIDENCE IN AN ARMED FORCES INSTALLATION X	
3. NAME OF DECEASED (Type or print) Nicholas Campofreda First Middle Last 4. DATE OF DEATH May 23 Month Day Year 19 59		5. SEX m 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 14, 1914 9. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Relations Dir. Brewery 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Anthony Campofreda 14. MOTHER'S MAIDEN NAME Eleanor Pietrunti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 213-18-0527 17. INFORMANT Mrs. Ellen T. Campofreda-Dulaney Va. Roa Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aortic aneurysm 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE A. M. France M.D. EXAMINER'S NAME (Type) A.M. France		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 26, 1959 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer 22d. LOCATION (City, town, or county) (State) Belair Rd. Balto., Md.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook-Towson, Inc. York Rd. Towson, Md. 24a. REC'D BY REGISTRAR DATE MAY 26 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05102

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE TIME
HEALTH DEPT.



HOSPITAL

RESIDENT

DATE

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled out with handwritten text.

1. Name of deceased: John A. Smith

2. Age: 45 Sex: M

3. Date of death: Jan 15, 1918

4. Place of death: Home

5. Cause of death: Heart failure

6. Medical history: None

7. Examination findings: Normal

8. Signature of Medical Examiner: [Signature]

5218

CERTIFICATE OF DEATH

Reg. Dist. No.

05193

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>602 St. Francis Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Howard E.</i> Middle <i>Cann</i> Last <i>Sr.</i>		4. DATE OF DEATH Month <i>May</i> Day <i>4th</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1897</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months <i>61</i> Days <i>61</i> Hours <i>61</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cann Waterproofing Company</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Howard Cann</i>		14. MOTHER'S MAIDEN NAME <i>Helen Price</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>218-18-1047</i>	
17. INFORMANT <i>Mrs. Alice V. Cann</i>		Address <i>602 St. Francis Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153.8 Carcinomatosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Carcinoma of Colon</i> (c) <i>2 1/2 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 6th</i> , 1959, to <i>MAY 4th</i> , 1959, that I last saw the deceased alive on <i>MAY 4th</i> , 1959, and that death occurred at <i>12:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. X. Quinn</i>		DATE SIGNED <i>1927 York Rd, TIMONIDIA, MD 5/5/59</i>	
PHYSICIAN'S NAME (Type) <i>M. X. Quinn</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/7/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>MAY 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 5219 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05194

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (12)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Haven Nursing Home Inc.</u>		d. STREET ADDRESS <u>120 Dunkirk Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Agnes B. Carr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH <u>May 1st 1959</u>
8. DATE OF BIRTH <u>12-27-1877</u>		9. AGE (In years, last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Carr</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Welsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Dr. Jerry H. Kernan</u>		Address <u>120 Dunkirk Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Coronary Vascular Disease</u> DUE TO (c) <u>DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>58</u> , to <u>5/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/1</u> , 19 <u>59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		DATE SIGNED <u>5/1/59</u>	
PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>		DATE SIGNED <u>MAY 28, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>4300 Old Dunkirk Rd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Knaus</u>	
ADDRESS <u>9 Collins St.</u>		DATE <u>MAY 4 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5220 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosewood St. School</u> c. LENGTH OF STAY IN 1b <u>4 mo.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto c. t.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> d. STREET ADDRESS <u>712 Climore Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Valarie</u> First Middle Last 4. DATE OF DEATH <u>5</u> <u>17</u> <u>1959</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-10-59</u> 9. AGE (In years lost birthday) yrs. <u>9</u> <u>7</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Earl Frederick K Carroll</u> 14. MOTHER'S MAIDEN NAME <u>Albertine Bethea</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>Rosewood Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Branchiopneumonia, bilateral</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malformation of Brain</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>5-17</u> , 19 <u>54</u> , to <u>5-17</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>54</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave</u> DATE SIGNED <u>5-17-54</u> ACTUAL SIGNATURE <u>Pete W. Rieckert</u> PHYSICIAN'S NAME (Type) <u>Pete W. Rieckert</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/19/59</u> 22b. DATE THEREOF <u>5/19/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Not Auburn</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rieckert</u> ADDRESS <u>661 W. Barre St</u> 24a. REC'D BY REGISTRAR <u>MAY 20 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2036236xvV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4,8 FilmG242 5-7-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05196

1. PLACE OF DEATH a. COUNTY Paradise Nursing Home Baltimore Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Md.		c. LENGTH OF STAY IN 1b 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle A. Last (Corson) Carson		4. DATE OF DEATH Month July Day 30 Year 1897	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1959
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? 21	
13. FATHER'S NAME ----- Corson		14. MOTHER'S MAIDEN NAME Evelyn -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT John J. Beyer, 208 Holly Neck Rd.		Address 21	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accidents 331x DUE TO Multiple. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19 Mar 59		20f. (City or town) 5/5/59 (County) Balto. Co. (State) Md.	
21. I certify that I attended the deceased from 19 Mar 59 to 5/5/59 , that I last saw the deceased alive on 5/4/59 , 19 59 , and that death occurred at 3:40 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28 md	
ACTUAL SIGNATURE W. E. Mc Grath		DATE SIGNED 5/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
ADDRESS 2024 Orleans St. 31		24b. REGISTRAR'S SIGNATURE Arthur A. ...	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13, 17 Film G242 5-13-59 et

Reg. Dist. No.

05197

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTO. 5222 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex - 21		c. LENGTH OF STAY IN 1b BALTIMORE 3001.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wildwood Beach		d. STREET ADDRESS 1814 E. BALTIMORE ST.	
3. NAME OF DECEASED (Type or print) GRADY HAROLD CHAVIS Chavis		4. DATE OF DEATH 5-3-59	
5. SEX M-	6. COLOR OR RACE INDIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12, 1933 26 yrs.
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY USED CAR	
11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BENJAMIN CHAVIS Chavis		14. MOTHER'S MAIDEN NAME DEBIE LOCHLEAR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 239-42-0968	
17. INFORMANT HUTHAN CHAVIS		Address SAME	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
INTERVAL BETWEEN ONSET AND DEATH —			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Small Boat Overturned in Back River.	
20c. TIME OF INJURY Month, Day, Year 3 May 5-3 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back River	20f. (City or town) Essex - 21 (County) BALTO. MD (State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. DAVIS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M B Davis		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-4-1959		22b. DATE THEREOF 5-4-1959	
22c. NAME OF CEMETERY OR CREMATORY Berea Cemetery		22d. LOCATION (City, town, or county) Pembroke Co. Roanoke VA (State) VA	
23. FUNERAL DIRECTOR'S SIGNATURE James Brydgen		24a. REC'D BY REGISTRAR MAY 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5223

Item 9 Film G243 5/27/59 cap

CERTIFICATE OF DEATH

05198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Catoctin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville, Maryland</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				/d. STREET ADDRESS <u>110 Old Court Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Philistia</u> Last <u>Chenoweth</u>				4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/14/1871</u>		9. AGE (In years last birthday) <u>88 1/2</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Breighner</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Little</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 19</u> , 19 <u>59</u> , to <u>MAY 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 19</u> , 19 <u>59</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <u>TIMONIUM, MD.</u> DATE SIGNED <u>5/20/59</u>	
ACTUAL SIGNATURE <u>William H. Pillsbury</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Hew-ell</u> ADDRESS <u>Pikesville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

100

52241/2 CERTIFICATE OF DEATH

Reg. Dist. No.

05199

1. PLACE OF DEATH a. COUNTY <u>321 DUNKER RD BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>322 OVERBROOK RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>Agnes</u> Last <u>Cherry</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>M. HANNA</u>		14. MOTHER'S MAIDEN NAME <u>Markesey Anna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give year or dates of service) <u>NO</u>		17. INFORMANT <u>Husband - FRANK Cherry</u> Address <u>322 Overbrook</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture Coronary artery</u> <u>400.X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Rheumatic fever shock</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-26-</u> 19 <u>59</u> , to <u>5-27-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5-27-</u> 19 <u>59</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor Richards</u> M.D.		ADDRESS (Street, city or town, state) <u>321 Dunker Rd</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>C. VICTOR RICHARDS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. JENKINS & SONS Co.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
ADDRESS <u>4905 YORK RD. BALTO. 12</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>		c. LENGTH OF STAY IN lb <u>?</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>603 Regester Ave</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>	
f. NAME OF DECEASED (Type or print) <u>MARY KATHRYN CLARK</u>		g. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>	
h. SEX <u>F</u>		i. COLOR OR RACE <u>W</u>	
j. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		k. DATE OF BIRTH <u>Oct 13 1908</u>	
l. AGE (In years last birthday) <u>50</u> yrs.		m. IF UNDER 1 YEAR Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>	
n. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		o. KIND OF BUSINESS OR INDUSTRY <u>Lawyers Office Ashland Md</u>	
p. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		q. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
r. FATHER'S NAME <u>Richard M Cross</u>		s. MOTHER'S MAIDEN NAME <u>Ida Jones</u>	
t. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		u. SOCIAL SECURITY NO. <u>Chas S Clark Jr.</u>	
v. ADDRESS <u>Same</u>		w. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, Gall Bladder</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
x. INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		y. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
z. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		aa. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
ab. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		ac. 20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>	
ad. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		ae. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
af. 20f. (City or town)		ag. (County)	
ah. (State)		ai. 21. I certify that I attended the deceased from <u>NOVEMBER, 1958</u> to <u>MAY, 1959</u> , that I last saw the deceased alive on <u>30 APRIL, 1959</u> , and that death occurred at <u>9:00 A</u> M, from the causes and on the date stated above.	
aj. ACTUAL SIGNATURE <u>John B. DeHoff</u>		ak. ADDRESS (Street, city or town, state) <u>Loch Raven Shopping Center Balto. 12, Md.</u>	
al. DATE SIGNED <u>1 May 59</u>		am. 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
an. 22b. DATE THEREOF <u>May 4 1959</u>		ao. 22c. NAME OF CEMETERY OR CREMATORY <u>Kulany Valley Mem Garden</u>	
ap. 22d. LOCATION (City, town, or county) <u>Cockeysville Md</u>		aq. 22e. LOCATION (City, town, or county) <u>Cockeysville Md</u>	
ar. 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Jenkins</u>		as. ADDRESS <u>Box 4905 York Rd</u>	
at. 24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>		au. 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05201

Items 22c, 22d Film 0242 5-19-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5226 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY NEW YORK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b 69x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 39 Edgewood Lane	
3. NAME OF DECEASED (Type or print) GRACE C. CLEARY		4. DATE OF DEATH May 12 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1915
9. AGE (in years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Cincinnati, Ohio	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Bernard C. Chenal	
14. MOTHER'S MAIDEN NAME Grace Guilfoyle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Fred.H. McGrath & Son, 20 Cedar St N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 59	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	
20f. (City or town) Chase		(County) Balto. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		22d. LOCATION (City, town, or county) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR 5/14/59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your filing office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05202**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5227 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bronxville 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 39 Edgewood Lane	
3. NAME OF DECEASED (Type or print) Maurice D		4. DATE OF DEATH May 12 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1912
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director Industrial Rel. Inter. Chemical Co.		10b. KIND OF BUSINESS OR INDUSTRY OHIO	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 289-14-2230	
17. INFORMANT Fred. H. McGraff & Son		Address Bronxville N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	20f. (City or town) (County) (State) Chase Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem. Bronxville, New York		22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Balto.		24a. REC'D BY REGISTRAR DATE MAY 15 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5228 CERTIFICATE OF DEATH

06411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 35 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3701.4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 3709, CRANSTON AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DOROTHY LEE CLEMENS		4. DATE OF DEATH 5 31 1959	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/21/13	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GROVER BAUGHER SR.		14. MOTHER'S MAIDEN NAME TESSIE McDORMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-188883	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/27 , 19 59 , to 5/31 , 19 59 , that I last saw the deceased alive on 5/30 , 19 59 , and that death occurred at 1:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Newcomer		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland	
DATE SIGNED			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Clinton Cemetery		22d. LOCATION (City, town, or county) (State) Rockingham County, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lynette A. Lutz ADDRESS Harrodsburg Va		24a. REC'D BY REGISTRAR JUN 9 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Knaus			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

NAME OF ASSISTANT

NAME OF CLERK

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

5229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Timothy's Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE EGERTON COATES</u>				4. DATE OF DEATH Month Day Year <u>May 17, 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1882</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Spencer T. Oldham</u>				14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss Miriam O. Coates - St. Timothy's Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic CVD</u> DUE TO (c) <u>Coronary</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular Accident</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January</u> , 19 <u>59</u> , to <u>5/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>59</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Nolan</u>				ADDRESS (Street, city or town, state) <u>Mallory Hill Ave Baltimore</u>		DATE SIGNED <u>24 May 59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Sicker & Sons - Balt</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALVIN BOMB

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEAREST RELATIVE	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF CHURCH OFFICIAL		18. SIGNATURE OF MINISTER		19. SIGNATURE OF RABBI		20. SIGNATURE OF OTHER OFFICIAL	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF JURY	
26. SIGNATURE OF DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF TOWNSHIP CLERK		29. SIGNATURE OF VILLAGE CLERK		30. SIGNATURE OF CITY CLERK	
31. SIGNATURE OF STATE CLERK		32. SIGNATURE OF FEDERAL CLERK		33. SIGNATURE OF MARSHAL		34. SIGNATURE OF DEPUTY MARSHAL		35. SIGNATURE OF JAILER	
36. SIGNATURE OF PRISONER		37. SIGNATURE OF GUARD		38. SIGNATURE OF WARDEN		39. SIGNATURE OF DEPUTY WARDEN		40. SIGNATURE OF CHIEF OF POLICE	
41. SIGNATURE OF DETECTIVE		42. SIGNATURE OF SHERIFF'S DEPUTY		43. SIGNATURE OF JURY MEMBER		44. SIGNATURE OF JURY MEMBER		45. SIGNATURE OF JURY MEMBER	
46. SIGNATURE OF JURY MEMBER		47. SIGNATURE OF JURY MEMBER		48. SIGNATURE OF JURY MEMBER		49. SIGNATURE OF JURY MEMBER		50. SIGNATURE OF JURY MEMBER	
51. SIGNATURE OF JURY MEMBER		52. SIGNATURE OF JURY MEMBER		53. SIGNATURE OF JURY MEMBER		54. SIGNATURE OF JURY MEMBER		55. SIGNATURE OF JURY MEMBER	
56. SIGNATURE OF JURY MEMBER		57. SIGNATURE OF JURY MEMBER		58. SIGNATURE OF JURY MEMBER		59. SIGNATURE OF JURY MEMBER		60. SIGNATURE OF JURY MEMBER	
61. SIGNATURE OF JURY MEMBER		62. SIGNATURE OF JURY MEMBER		63. SIGNATURE OF JURY MEMBER		64. SIGNATURE OF JURY MEMBER		65. SIGNATURE OF JURY MEMBER	
66. SIGNATURE OF JURY MEMBER		67. SIGNATURE OF JURY MEMBER		68. SIGNATURE OF JURY MEMBER		69. SIGNATURE OF JURY MEMBER		70. SIGNATURE OF JURY MEMBER	
71. SIGNATURE OF JURY MEMBER		72. SIGNATURE OF JURY MEMBER		73. SIGNATURE OF JURY MEMBER		74. SIGNATURE OF JURY MEMBER		75. SIGNATURE OF JURY MEMBER	
76. SIGNATURE OF JURY MEMBER		77. SIGNATURE OF JURY MEMBER		78. SIGNATURE OF JURY MEMBER		79. SIGNATURE OF JURY MEMBER		80. SIGNATURE OF JURY MEMBER	
81. SIGNATURE OF JURY MEMBER		82. SIGNATURE OF JURY MEMBER		83. SIGNATURE OF JURY MEMBER		84. SIGNATURE OF JURY MEMBER		85. SIGNATURE OF JURY MEMBER	
86. SIGNATURE OF JURY MEMBER		87. SIGNATURE OF JURY MEMBER		88. SIGNATURE OF JURY MEMBER		89. SIGNATURE OF JURY MEMBER		90. SIGNATURE OF JURY MEMBER	
91. SIGNATURE OF JURY MEMBER		92. SIGNATURE OF JURY MEMBER		93. SIGNATURE OF JURY MEMBER		94. SIGNATURE OF JURY MEMBER		95. SIGNATURE OF JURY MEMBER	
96. SIGNATURE OF JURY MEMBER		97. SIGNATURE OF JURY MEMBER		98. SIGNATURE OF JURY MEMBER		99. SIGNATURE OF JURY MEMBER		100. SIGNATURE OF JURY MEMBER	

1

RECEIVED
JANUARY 1918
BALTIMORE

5230

CERTIFICATE OF DEATH

05204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2626 Edgemere Ave.				e. STREET ADDRESS 2626 Edgemere Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle CARTER Last COATES				4. DATE OF DEATH Month May Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1894	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Smelter				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Smith M. Coates				14. MOTHER'S MAIDEN NAME Ida V. Hensen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 213-07-4953		INFORMANT Clifford Coates, 130 Milford Drive. San Antonio Texas			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma, widespread 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the colon DUE TO (c) 8 mo. INTERVAL BETWEEN ONSET AND DEATH 6 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sparrows Point Balt Md.	
20f. (City or town) (County) (State) Balt Md.							
21. I certify that I attended the deceased from Nov 1 , 19 59 , to May 6 , 19 59 , that I last saw the deceased alive on May 6 , 19 59 , and that death occurred May 5 , 19 59 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D St., Balt 19, Md DATE SIGNED 5-7-59							
ACTUAL SIGNATURE John V. Conway M.D.							
PHYSICIAN'S NAME (Type) John V. Conway							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Bumpy Oak Cemetery		22d. LOCATION (City, town, or county) (State) Pomonker, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				24a. REC'D BY REGISTRAR DATE MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03204

81

MEMORANDUM
TO : THE SECRETARY OF THE ARMY
FROM : THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

1 4 090 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 090 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5231 Item 1 Film 243 6-5-59 et 5231 CERTIFICATE OF DEATH

Reg. Dist. No.

05205

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor 5713 Edmondson Ave.				d. STREET ADDRESS 4655 Manordene Rd.			
3. NAME OF DECEASED (Type or print) EMALINE HART COOPER				4. DATE OF DEATH Month May Day 29 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1876	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer (rtd)				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Alpheus W. Hart				14. MOTHER'S MAIDEN NAME Mary Ann Harden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Hart Cooper-22 W. 40th St., Wilmington, Del.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 5, 1958 to May 29, 1959 that I last saw the deceased alive on May 29, 1959 and that death occurred at 2:15 PM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 651 N. Beutalou St DATE SIGNED 5/29/59							
ACTUAL SIGNATURE C J Mendelis M.D. Baltimore 16-Md.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/1/59			
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Jim. J. Tiekner & Sons - Balt				24a. REC'D BY REGISTRAR DATE JUN 1 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5232 CERTIFICATE OF DEATH

Reg. Dist. No. 05206

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 Spring St.</u>				d. STREET ADDRESS <u>6 Spring St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN ALBERT CRAMBLITT</u>				4. DATE OF DEATH Month Day Year <u>May 24, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-14-9666</u>		17. INFORMANT <u>Mrs. Esther Zellmer, Oella, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular DISEASE</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-9</u> , 19 <u>59</u> , to <u>5-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>59</u> , and that death occurred at <u>11:15 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>COLUMBIA RD</u> DATE SIGNED <u>5-25-59</u> ACTUAL SIGNATURE <u>P. V. Thorpe</u> M.D. <u>PETER V. THORPE MD</u> PHYSICIAN'S NAME (Type) <u>ELLICOTT CITY, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

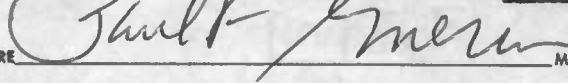
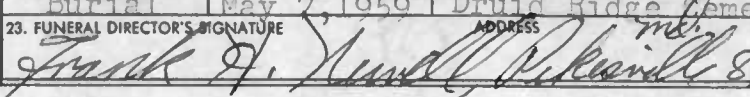
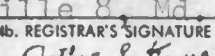
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...the ... of ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05207**

1. PLACE OF DEATH o. COUNTY Baltimore 5233 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wiltonwood Road				d. STREET ADDRESS Wiltonwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stuart Middle Celby Last CROOKS				4. DATE OF DEATH Month May Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1944	
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 15 Days 15		IF UNDER 24 HRS. Hours 15 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School			10b. KIND OF BUSINESS OR INDUSTRY Sudbrook High			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gordon L. Crooks				14. MOTHER'S MAIDEN NAME Libby Charchee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Pikesville Police, Pikesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Gunshot Wounds of Chest. DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5/5 19 59 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Stevenson Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/6/59	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS Pikesville 8, Md.		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
				24b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF BALTIMORE DISTRICT OF BALTIMORE		DEATH NO. 1000 DATE OF DEATH 10-10-1910	
NAME OF DECEASED JAMES M. JONES		SEX MALE AGE 45	
OCCUPATION LABORER		PLACE OF BIRTH BALTIMORE, MD.	
MARITAL STATUS SINGLE		COLOR WHITE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME	
SIGNATURE OF EXAMINER J. M. JONES		SIGNATURE OF WITNESS J. M. JONES	
CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as they appear to me.		I hereby certify that the above is a true and correct statement of the facts as they appear to me.	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5169

CERTIFICATE OF DEATH

05208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSURANCE 6902 Morningson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle FRANCIS Last DANAHY, Jr.		4. DATE OF DEATH Month May Day 30th Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert F. Danahy, Sr.		14. MOTHER'S MAIDEN NAME Margaret Nugent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-3856	
17. INFORMANT Virginia W. Danahy		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V Disease & AORTIC 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INSUFFICIENCY & Stenosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm of the Thoracic Aorta			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30 , 19 57 to May 30 , 19 59 , that I last saw the deceased alive on May 30 , 19 59 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6800 Morningson Road DATE SIGNED ACTUAL SIGNATURE M. B. Davis M.D. PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D. Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Jr.		24a. REC'D BY REGISTRAR DATE JUN 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG243 6-8-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 05209

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>5234</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Catonsville</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>"Private home"</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Catonsville</u> TOWN STREET ADDRESS <u>4 Sanford Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Beryl E Davenport</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>May 31 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 1 1884</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Orkney New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS <u>Mrs Adelbert Moody</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Coronary heart failure due to</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis (CV Disease)</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1958</u> , to <u>May 31, 1959</u> , that I last saw the deceased alive on <u>May 31, 1959</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Veas S. Pasquz MD</u>		DATE SIGNED <u>6/1/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/4/59</u>	
NAME OF CEMETERY OR CREMATORY <u>Orkney Cem</u>		LOCATION (City, town, or county) (State) <u>Orkney N.Y.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel J. Lee</u> ADDRESS <u>304 Mt Holly</u>	

00800

CERTIFICATE OF DEATH

REG. DIST. NO.

STATE DEPARTMENT OF HEALTH

DEATH

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CITY

STATE

COUNTRY

ZIP CODE

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

ZIP CODE

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

ZIP CODE

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, but not later than 48 hours after death. It should be signed by the physician or other qualified person who attended the deceased during his or her last illness. It should be filed with the local health department or other authority having jurisdiction over the death. It should be kept for a period of 10 years.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 1055 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 d. STREET ADDRESS 5101 Sargent Rd., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ANTHONY DAVIS				4. DATE OF DEATH Month Day Year May 12 19 59									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 28, 1921		9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 12 19 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) staff superintendent				10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tele. Co				11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Calvin C. Davis						14. MOTHER'S MAIDEN NAME Irene Douglass							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. 11 578-05-7303		17. INFORMANT Mrs. Geo. A. Davis				Address 5101 Sargent Rd. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash									
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 19 59				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) Chase		(County) Balto.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Charles O'Donnell</i> M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												DATE SIGNED <i>5/12/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc., Baltimore, Md.						ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

03210

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 40		SEX Male		RACE White		DATE OF DEATH May 15, 1934		PLACE OF DEATH Home	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical		HISTORY Long standing		FAMILY HISTORY None	
SIGNATURE OF EXAMINER J. H. Smith		TITLE Medical Examiner		DATE May 15, 1934		PLACE Baltimore, Md.		COUNTY Baltimore		STATE Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **05211**

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb 14 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2701 N. Charles Street (18)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCIS		First A. E.		Middle DeBULLET	
4. DATE OF DEATH May		Month 7		Day 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH April 30, 1906		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance (Blue Cross)		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Leon DeBullet		14. MOTHER'S MAIDEN NAME Laura Whiteley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: Exploratory Laparotomy 4/14/59 at Union Memorial Hospital		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA		(County) VA		(State) VA	
21. I certify that I attended the deceased from April 23 , 19 59 , to May 7 , 19 59 , and that death occurred at 10:10P M, from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) VA HOSPITAL, Fort Howard, Md.		DATE SIGNED 5/8/59	
ACTUAL SIGNATURE John W. Crawford		M.D. VA HOSPITAL, Fort Howard, Md.		DATE SIGNED 5/8/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell		ADDRESS & Sons Inc. 1900 Eutaw Pl. Balto, Md.		24a. REC'D BY REGISTRAR MAY 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAILED
JAN 10 1918

CERTIFICATE OF DEATH

113-8-311

NAME OF DECEASED JAMES J. HENRY		AGE 45		SEX Male	
DATE OF DEATH Jan 10 1918		PLACE OF DEATH Boston		CITY Boston	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Heart Disease		MEDICAL ATTENDANT Dr. J. H. Smith	
DATE OF BIRTH Jan 10 1873		PLACE OF BIRTH Boston		CITY Boston	
FATHER'S NAME John Henry		MOTHER'S NAME Mary Henry		MARRIAGE DATE Jan 10 1900	
FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Housewife		MARRIAGE PLACE Boston	
FATHER'S RESIDENCE Boston		MOTHER'S RESIDENCE Boston		MARRIAGE REGISTERED Yes	
FATHER'S DEATH DATE Jan 10 1910		MOTHER'S DEATH DATE Jan 10 1910		MARRIAGE REGISTERED Yes	
FATHER'S DEATH PLACE Boston		MOTHER'S DEATH PLACE Boston		MARRIAGE REGISTERED Yes	
FATHER'S DEATH CAUSE Heart Disease		MOTHER'S DEATH CAUSE Heart Disease		MARRIAGE REGISTERED Yes	
FATHER'S DEATH MEDICAL ATTENDANT Dr. J. H. Smith		MOTHER'S DEATH MEDICAL ATTENDANT Dr. J. H. Smith		MARRIAGE REGISTERED Yes	
FATHER'S DEATH DATE Jan 10 1910		MOTHER'S DEATH DATE Jan 10 1910		MARRIAGE REGISTERED Yes	
FATHER'S DEATH PLACE Boston		MOTHER'S DEATH PLACE Boston		MARRIAGE REGISTERED Yes	
FATHER'S DEATH CAUSE Heart Disease		MOTHER'S DEATH CAUSE Heart Disease		MARRIAGE REGISTERED Yes	
FATHER'S DEATH MEDICAL ATTENDANT Dr. J. H. Smith		MOTHER'S DEATH MEDICAL ATTENDANT Dr. J. H. Smith		MARRIAGE REGISTERED Yes	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>AGE [Faint text, possibly "45"]</p>	
<p>SEX [Faint text, possibly "Male"]</p>		<p>RACE [Faint text, possibly "White"]</p>	
<p>DATE OF DEATH [Faint text, possibly "Jan 15, 1910"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Heart failure"]</p>		<p>IMMEDIATE CAUSE [Faint text, possibly "Myocardial infarction"]</p>	
<p>PREVAILING DISEASE [Faint text, possibly "Hypertension"]</p>		<p>DATE OF BIRTH [Faint text, possibly "Jan 1, 1865"]</p>	
<p>PLACE OF BIRTH [Faint text, possibly "Maryland"]</p>		<p>DATE OF DEATH [Faint text, possibly "Jan 15, 1910"]</p>	
<p>DATE OF DEATH [Faint text, possibly "Jan 15, 1910"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Heart failure"]</p>		<p>IMMEDIATE CAUSE [Faint text, possibly "Myocardial infarction"]</p>	
<p>PREVAILING DISEASE [Faint text, possibly "Hypertension"]</p>		<p>DATE OF BIRTH [Faint text, possibly "Jan 1, 1865"]</p>	
<p>PLACE OF BIRTH [Faint text, possibly "Maryland"]</p>		<p>DATE OF DEATH [Faint text, possibly "Jan 15, 1910"]</p>	

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 5238 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nicodemus Rd.				h. STREET ADDRESS Berryman's Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Edward Last DeVese				4. DATE OF DEATH Month May Day 11 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1889		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cattle Dealer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. DeVese				14. MOTHER'S MAIDEN NAME Mary E. Fishpaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-1035		17. INFORMANT Grace M. DeVese		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 976x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head					
20c. TIME OF INJURY Month, Day, Year Hour 10:30 a.m. 5/11 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles S. Petty</i> EXAMINER'S NAME (Type) Charles S. Petty, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 5/12/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Gardens		22d. LOCATION (City, town, or county) (State) Finksburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR May 14 '59	
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Petty</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN A. DAVEN		2. SEX MALE		3. AGE 38		4. RACE WHITE	
5. PLACE OF BIRTH NEW YORK		6. DATE OF BIRTH 1921		7. PLACE OF DEATH BALTIMORE		8. DATE OF DEATH 1958	
9. OCCUPATION ENGINEER		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. SIGNATURE OF EXAMINER [Signature]	
13. SIGNATURE OF NEXT OF KIN [Signature]		14. SIGNATURE OF PHYSICIAN [Signature]		15. SIGNATURE OF CORONER [Signature]		16. SIGNATURE OF JURY [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF WITNESS [Signature]	
29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]		31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]	
33. SIGNATURE OF WITNESS [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]	
45. SIGNATURE OF WITNESS [Signature]		46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]		52. SIGNATURE OF WITNESS [Signature]	
53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]	
57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]		64. SIGNATURE OF WITNESS [Signature]	
65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]	
69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]		76. SIGNATURE OF WITNESS [Signature]	
77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]		79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]	
81. SIGNATURE OF WITNESS [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF WITNESS [Signature]	
89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]		91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5239

CERTIFICATE OF DEATH

05214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 6</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>32 Sipple Avenue</u>		d. STREET ADDRESS <u>32 Sipple Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>IRENE S. DIX</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	9. AGE (In years last birthday) <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harvey Jones</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Mr. Vernon Dix - 14402 Marble Hall Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>hypertension</u> (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>oct 18</u> , 19 <u>58</u> , to <u>may 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>may 6</u> , 19 <u>59</u> , and that death occurred at <u>5:45 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rigley</u>		ADDRESS (Street, city or town, state) <u>1W. OVERLEA AVE BALTO, MD.</u>	
PHYSICIAN'S NAME (Type) <u>DR. RIGLEY</u>		DATE SIGNED <u>5-12-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balt</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	
ADDRESS <u>1111</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

CERTIFICATE OF DEATH

3-33

6-1-33

JAMES B. BORD

Name of Deceased		JAMES B. BORD	
Date of Death		March 3, 1933	
Place of Death		Home	
Age		68 years	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Retired	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Artery Disease	
Contributing Cause		Hypertension	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		March 3, 1933	
Place of Registration		Baltimore, MD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 FilmG242 5-18-59 et

Reg. Dist. No. 05329

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> <u>5240</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>903 Edmonson ave</u>		d. STREET ADDRESS <u>903 Edmonson ave</u>	
3. NAME OF DECEASED (Type or print) <u>Serena V. Dixon</u> <u>Randall</u>		4. DATE OF DEATH <u>May 9</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 2 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 YRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>	
13. FATHER'S NAME <u>John T. Dorsey</u>		14. MOTHER'S MARDEN NAME <u>Catharine Fletcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ms 12212 E</u>	
17. INFORMANT <u>Serena V. Dixon</u>		Address <u>903 Edmonson ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Vascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>GEO. S. M. KIEFFER</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bushey Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. Hemsley</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hems</u>	
ADDRESS <u>578 W. Biddle St</u>		DATE <u>MAY 13 '59</u>	

1. NAME OF DECEASED Mrs. Thomas A. Hamilton		2. SEX Female		3. AGE 65	
4. PLACE OF BIRTH Baltimore, Md.		5. DATE OF BIRTH Jan 15, 1895		6. OCCUPATION Homemaker	
7. MARITAL STATUS Married		8. RACE White		9. RELIGION Roman Catholic	
10. PLACE OF DEATH Home		11. DATE OF DEATH Jan 15, 1960		12. TIME OF DEATH 10:30 AM	
13. CAUSE OF DEATH Myocardial infarction		14. MANNER OF DEATH Natural		15. SIGNATURE OF EXAMINER [Signature]	
16. SIGNATURE OF ATTENDING PHYSICIAN [Signature]		17. SIGNATURE OF WITNESSES [Signatures]		18. SIGNATURE OF FUNERAL HOME [Signature]	
19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JURY [Signatures]		21. SIGNATURE OF STATE DEPARTMENT OF HEALTH [Signature]	

Arthur L. Howard

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JOHN J. HARRIS		1944	
AGE		SEX	
40 years		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		RESIDENCE	
Carpenter		1234 Main St., Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Failure		Natural	
DATE OF BURIAL		PLACE OF BURIAL	
1944		St. Mary's Cemetery, Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		PLACE	
1944		Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5242 CERTIFICATE OF DEATH

Reg. Dist. No.

05216

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>1641-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stuart</u> Middle <u>Winston</u> Last <u>Dorset</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calhoun Hawkins Dorset</u>		14. MOTHER'S MAIDEN NAME <u>Stella Crump</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>indefinite</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 13</u> , 1959, to <u>May 20</u> , 1959, that I last saw the deceased alive on <u>May 20</u> , 1959, and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James Donald Drinkard</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>James Donald Drinkard, M.D.</u>		<u>Spring Grove State Hospital, Catonsville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/23/59</u>	<u>Lakewood Cem</u>	<u>Richmond Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Donald Drinkard</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. & K. H. H.</u>

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05217**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5243 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1431 Bellona Ave.				d. STREET ADDRESS 1431 Bellona Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Morgan Last Dorsey				4. DATE OF DEATH Month May Day 24 Year 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6 1895	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 8 Days 4	IF UNDER 24 HRS. Hours 10 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Self. family		11. BIRTHPLACE (State or foreign country) St. Mary Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 4917 Alhambra Ave. 33		17. SPOUSE Mrs. Sarah C. Williams			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Renal DUE TO (c) Vascular Disease INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/59		22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest		22d. LOCATION (City, town, or county) (State) Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William				24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00317

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH REPORT

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15, 1968</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		10. SIGNATURE OF EXAMINER <i>[Signature]</i>	
11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF CORONER <i>[Signature]</i>	
13. SIGNATURE OF JURY <i>[Signature]</i>		14. SIGNATURE OF JURY <i>[Signature]</i>	
15. SIGNATURE OF JURY <i>[Signature]</i>		16. SIGNATURE OF JURY <i>[Signature]</i>	
17. SIGNATURE OF JURY <i>[Signature]</i>		18. SIGNATURE OF JURY <i>[Signature]</i>	
19. SIGNATURE OF JURY <i>[Signature]</i>		20. SIGNATURE OF JURY <i>[Signature]</i>	
21. SIGNATURE OF JURY <i>[Signature]</i>		22. SIGNATURE OF JURY <i>[Signature]</i>	
23. SIGNATURE OF JURY <i>[Signature]</i>		24. SIGNATURE OF JURY <i>[Signature]</i>	
25. SIGNATURE OF JURY <i>[Signature]</i>		26. SIGNATURE OF JURY <i>[Signature]</i>	
27. SIGNATURE OF JURY <i>[Signature]</i>		28. SIGNATURE OF JURY <i>[Signature]</i>	
29. SIGNATURE OF JURY <i>[Signature]</i>		30. SIGNATURE OF JURY <i>[Signature]</i>	
31. SIGNATURE OF JURY <i>[Signature]</i>		32. SIGNATURE OF JURY <i>[Signature]</i>	
33. SIGNATURE OF JURY <i>[Signature]</i>		34. SIGNATURE OF JURY <i>[Signature]</i>	
35. SIGNATURE OF JURY <i>[Signature]</i>		36. SIGNATURE OF JURY <i>[Signature]</i>	
37. SIGNATURE OF JURY <i>[Signature]</i>		38. SIGNATURE OF JURY <i>[Signature]</i>	
39. SIGNATURE OF JURY <i>[Signature]</i>		40. SIGNATURE OF JURY <i>[Signature]</i>	
41. SIGNATURE OF JURY <i>[Signature]</i>		42. SIGNATURE OF JURY <i>[Signature]</i>	
43. SIGNATURE OF JURY <i>[Signature]</i>		44. SIGNATURE OF JURY <i>[Signature]</i>	
45. SIGNATURE OF JURY <i>[Signature]</i>		46. SIGNATURE OF JURY <i>[Signature]</i>	
47. SIGNATURE OF JURY <i>[Signature]</i>		48. SIGNATURE OF JURY <i>[Signature]</i>	
49. SIGNATURE OF JURY <i>[Signature]</i>		50. SIGNATURE OF JURY <i>[Signature]</i>	
51. SIGNATURE OF JURY <i>[Signature]</i>		52. SIGNATURE OF JURY <i>[Signature]</i>	
53. SIGNATURE OF JURY <i>[Signature]</i>		54. SIGNATURE OF JURY <i>[Signature]</i>	
55. SIGNATURE OF JURY <i>[Signature]</i>		56. SIGNATURE OF JURY <i>[Signature]</i>	
57. SIGNATURE OF JURY <i>[Signature]</i>		58. SIGNATURE OF JURY <i>[Signature]</i>	
59. SIGNATURE OF JURY <i>[Signature]</i>		60. SIGNATURE OF JURY <i>[Signature]</i>	
61. SIGNATURE OF JURY <i>[Signature]</i>		62. SIGNATURE OF JURY <i>[Signature]</i>	
63. SIGNATURE OF JURY <i>[Signature]</i>		64. SIGNATURE OF JURY <i>[Signature]</i>	
65. SIGNATURE OF JURY <i>[Signature]</i>		66. SIGNATURE OF JURY <i>[Signature]</i>	
67. SIGNATURE OF JURY <i>[Signature]</i>		68. SIGNATURE OF JURY <i>[Signature]</i>	
69. SIGNATURE OF JURY <i>[Signature]</i>		70. SIGNATURE OF JURY <i>[Signature]</i>	
71. SIGNATURE OF JURY <i>[Signature]</i>		72. SIGNATURE OF JURY <i>[Signature]</i>	
73. SIGNATURE OF JURY <i>[Signature]</i>		74. SIGNATURE OF JURY <i>[Signature]</i>	
75. SIGNATURE OF JURY <i>[Signature]</i>		76. SIGNATURE OF JURY <i>[Signature]</i>	
77. SIGNATURE OF JURY <i>[Signature]</i>		78. SIGNATURE OF JURY <i>[Signature]</i>	
79. SIGNATURE OF JURY <i>[Signature]</i>		80. SIGNATURE OF JURY <i>[Signature]</i>	
81. SIGNATURE OF JURY <i>[Signature]</i>		82. SIGNATURE OF JURY <i>[Signature]</i>	
83. SIGNATURE OF JURY <i>[Signature]</i>		84. SIGNATURE OF JURY <i>[Signature]</i>	
85. SIGNATURE OF JURY <i>[Signature]</i>		86. SIGNATURE OF JURY <i>[Signature]</i>	
87. SIGNATURE OF JURY <i>[Signature]</i>		88. SIGNATURE OF JURY <i>[Signature]</i>	
89. SIGNATURE OF JURY <i>[Signature]</i>		90. SIGNATURE OF JURY <i>[Signature]</i>	
91. SIGNATURE OF JURY <i>[Signature]</i>		92. SIGNATURE OF JURY <i>[Signature]</i>	
93. SIGNATURE OF JURY <i>[Signature]</i>		94. SIGNATURE OF JURY <i>[Signature]</i>	
95. SIGNATURE OF JURY <i>[Signature]</i>		96. SIGNATURE OF JURY <i>[Signature]</i>	
97. SIGNATURE OF JURY <i>[Signature]</i>		98. SIGNATURE OF JURY <i>[Signature]</i>	
99. SIGNATURE OF JURY <i>[Signature]</i>		100. SIGNATURE OF JURY <i>[Signature]</i>	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH COMMISSIONER, BIRMINGHAM, MISSISSIPPI, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, CITY OF BIRMINGHAM, MISSISSIPPI.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05218

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5244 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase c. LENGTH OF STAY IN 1b 69x-3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York d. STREET ADDRESS Stuyvesant (410 E. 20th St)			
3. NAME OF DECEASED (Type or print) LUCILLE HAYES				4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1909		9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months 5 Days 12	11. IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Patrick Hayes				14. MOTHER'S MAIDEN NAME Irene Moley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Johns-Ridout Funeral Home, Birmingham, Ala.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5/15 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles O'Donnell</i> EXAMINER'S NAME (Type) Charles O'Donnell, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				22d. LOCATION (City, town, or county) (State) Birmingham, Alabama		24a. REC'D BY REGISTRAR MAY 15 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05219

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5245 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69X-3		✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS Stuyvesant 410 E. 29th St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Orion		First T Middle Dozier Last		4. DATE OF DEATH May 12, 1959		Day 12 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1906		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Representative		10b. KIND OF BUSINESS OR INDUSTRY Socony Oil Company		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr Bryon Dozier				14. MOTHER'S MAIDEN NAME Iduma Doyle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Johns-Ridout's Funeral Home, Birmingham, Ala.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Birmingham, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05220

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore 5246 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Kansas City 62X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 447 East 55th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WILLIAM DRANNBAUER				4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1923		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY A. T. T.		11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Charles Drannbauer				14. MOTHER'S MAIDEN NAME Elsie (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. 103-14-9489		17. INFORMANT Address Kansas City, Mo. Mrs. Jamesana Drannbauer - 447 E. 55th St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year Hour 5:15 PM P. M. 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis, M.D.				DATE SIGNED 5/12/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/14/59		22c. NAME OF CEMETERY OR CREMATORY Kansas City Cem.		22d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Sickner & Sons - Balto 17th St.				24a. REC'D BY REGISTRAR DATE MAY 15 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Knaut	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5247

CERTIFICATE OF DEATH

05221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle DRYDEN Last		4. DATE OF DEATH Month May Day 30 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert L. Dryden		14. MOTHER'S MAIDEN NAME Marion Wetherill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John Williams-2918 N. Rogers Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. carcinoma of lge. intestine 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from about May 30, 1959 to May 30, 1959 , that I last saw the deceased alive on May 30, 1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 888 W. Lombard St. Balto., Md. DATE SIGNED 5-31-59			
ACTUAL SIGNATURE Es. Highstern		M.D. 888 W. Lombard St. Balto., Md.	
PHYSICIAN'S NAME (Type) Guastar Highstern			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Tappahannock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills,		c. LENGTH OF STAY IN 1b 22 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First Lawrence Middle DUFOR Last		4. DATE OF DEATH Month 5 Day 29 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/28
9. AGE (In years last birthday) yrs. 30		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Easton, Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Dufour		14. MOTHER'S MAIDEN NAME Kathryn M. Hurlock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rosewood Records		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO chronic congestive heart failure (c) Spasms PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spasms		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 28, 1959 , to May 29, 1959 , that I last saw the deceased alive on May 29, 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Vasconcellos		DATE SIGNED Rosewood State Tr. School	
PHYSICIAN'S NAME (Type) J. VASCONCELLOS		Address Owings Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 4, 1959		22b. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery	
22c. DATE THEREOF June 4, 1959		22d. LOCATION (City, town, or county) (State) Owings Mills Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hurlock		24a. REC'D BY REGISTRAR JUN 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hurlock		24c. DATE JUN 5 '59	

0322

CERTIFICATE OF DEATH

STANDARD STATE DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS

Blank form with faint horizontal lines and vertical columns for data entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05223

5249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1 mo. 17 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 29 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 510 Rock Glen Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Avondale First Virginia Middle Duvall Last		4. DATE OF DEATH Month May Day 31 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12- 25- 1878	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT (son) Mr. E. Maitland Duvall Jr. Address 510 Rock Glen Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral hydronephrosis DUE TO (c) Carcinoma of the urinary bladder						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 24 , 19 59 , to May 31 , 19 59 , that I last saw the deceased alive on May 31 , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-1-59 ACTUAL SIGNATURE Stella Wachslar M.D. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore 7, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Edmundson 4101 Edmundson Ave				24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Carlton L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05224**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 3253 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (20) c. LENGTH OF STAY IN lb LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 30 Leslie Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (20) d. STREET ADDRESS 30 Leslie Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARVILLE V. EARLE First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 20, 1899 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH May 8, 19 59 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY DuPont Chemical 11. BIRTHPLACE (State or foreign country) Chase, Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Earle 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Anne Edwards 16. SOCIAL SECURITY NO. 17. INFORMANT (SON) Carville R. Earle, 410 Oak Court, Balt 0.28 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE M. B. Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) M. B. Davis M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/8/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 11/59 22c. NAME OF CEMETERY OR CREMATORY Ebenezer Meth. Church Cemetery 22d. LOCATION (City, town, or county) (State) Chase 20, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Fitzke Funeral Directors ADDRESS 4101 Hammondson Ave. 24a. REC'D BY REGISTRAR DATE MAY 11 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Dept. of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05225

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 332 Lincoln Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle WASHINGTON Last ECKERS		4. DATE OF DEATH Month May Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Estate	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Henry Eckers	
14. MOTHER'S MAIDEN NAME Betty Justice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Family records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 YRS 10 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from JAN. 1959 to MAY 27, 1959 , that I last saw the deceased alive on MAY 26, 1959 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Pillsbury		ADDRESS (Street, city or town, state) TIMONIUM, MD	
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY		DATE SIGNED 5/28/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Sater's Cemetery		22d. LOCATION (City, town, or county) (State) Lutherville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5182

CERTIFICATE OF DEATH

05226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5200 Leeds Ave.</u>				d. STREET ADDRESS <u>5200 Leeds Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine D. Eckhardt</u>				4. DATE OF DEATH Month Day Year <u>May 23 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 12, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Harry Blankner 5200 Leeds Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 1959</u> to <u>May 23, 1959</u> , that I last saw the deceased alive on <u>May 21, 1959</u> , and that death occurred at <u>1230</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.				ADDRESS (Street, city or town, state) <u>5305 East Drive Baltimore - 27 Md.</u>			
DATE SIGNED <u>5/23/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambrase Inc. 1328 Sulphur Spring Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

5182

RECEIVED
JAN 11 1964
BALTIMORE
DEPT. OF HEALTH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		JAN 4 1968	
AGE		SEX	
35		M	
RACE		EDUCATION	
W		H	
OCCUPATION		MANNER OF DEATH	
S		N	
PLACE OF DEATH		CITY	
H		B	
COUNTY		STATE	
C		M	
SIGNATURE OF PHYSICIAN		DATE	
J. H. H. H.		JAN 4 1968	
SIGNATURE OF REGISTRAR		DATE	
J. H. H. H.		JAN 4 1968	
SIGNATURE OF WITNESS		DATE	
J. H. H. H.		JAN 4 1968	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05227

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u>		c. LENGTH OF STAY IN 1b <u>x Anneslie (Towson)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>602 Overbrook</u>		d. STREET ADDRESS <u>602 Overbrook</u>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK CECIL Ely</u>		4. DATE OF DEATH <u>May 31 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Balto Elec Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F Ely</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ehrhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>210-05-7232 A, B</u>	
17. INFORMANT <u>My F C Ely</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>4 Hrs.</u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial <u>June 4 1959</u>		<u>Lorraine Park</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Woodlawn Md.</u>		<u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jenkins</u>		ADDRESS <u>Ans Co 4905 York Rd</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 2 '59</u>		<u>Arthur L. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10522

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10522

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

PLACE OF DEATH

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1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

5253 CERTIFICATE OF DEATH

05228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 709 Walker Avenue		d. STREET ADDRESS 709 Walker Ave.	
3. NAME OF DECEASED (Type or print) First MARY Middle T. Last ENGLE		4. DATE OF DEATH Month May Day 24 Year 19 59	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec/10, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William T. Fifer		14. MOTHER'S MAIDEN NAME Mary Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. C. Roland Mays-203 Midhurst Rd. Balto. 12, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 7, 1956 , to May 24, 1959 , that I last saw the deceased alive on May 24, 1959 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7215 York Road, Baltimore 12, Md DATE SIGNED 5/25/59			
ACTUAL SIGNATURE S. J. Venable, Jr. M.D.		PHYSICIAN'S NAME (Type) S. J. Venable, Jr. M.D. Baltimore 12, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 27, 1959	22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Sam. J. Vickner & Sons - Balto. 17		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
24b. REGISTRAR'S SIGNATURE Crispin & Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE BIRTH CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MAY 19 1928		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
APRIL 4 1968		MEMPHIS, TENN.		SHOOTING	
AGE AT DEATH		SEX		RACE	
39 YEARS		MALE		WHITE	
MARRIED		OCCUPATION		EDUCATION	
YES		CONTRACTOR		HIGH SCHOOL	
NAME OF MOTHER		NAME OF FATHER		NAME OF SPOUSE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF BIRTH OF MOTHER		DATE OF BIRTH OF FATHER		DATE OF BIRTH OF SPOUSE	
MAY 19 1928		MAY 19 1928		MAY 19 1928	
PLACE OF BIRTH OF MOTHER		PLACE OF BIRTH OF FATHER		PLACE OF BIRTH OF SPOUSE	
MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
OCCUPATION OF MOTHER		OCCUPATION OF FATHER		OCCUPATION OF SPOUSE	
CONTRACTOR		CONTRACTOR		CONTRACTOR	
EDUCATION OF MOTHER		EDUCATION OF FATHER		EDUCATION OF SPOUSE	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF CITY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF BIRTH OF PHYSICIAN		DATE OF BIRTH OF HOSPITAL		DATE OF BIRTH OF CITY	
MAY 19 1928		MAY 19 1928		MAY 19 1928	
PLACE OF BIRTH OF PHYSICIAN		PLACE OF BIRTH OF HOSPITAL		PLACE OF BIRTH OF CITY	
MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
OCCUPATION OF PHYSICIAN		OCCUPATION OF HOSPITAL		OCCUPATION OF CITY	
CONTRACTOR		CONTRACTOR		CONTRACTOR	
EDUCATION OF PHYSICIAN		EDUCATION OF HOSPITAL		EDUCATION OF CITY	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
NAME OF CLERK		NAME OF REGISTRAR		NAME OF CITY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF BIRTH OF CLERK		DATE OF BIRTH OF REGISTRAR		DATE OF BIRTH OF CITY	
MAY 19 1928		MAY 19 1928		MAY 19 1928	
PLACE OF BIRTH OF CLERK		PLACE OF BIRTH OF REGISTRAR		PLACE OF BIRTH OF CITY	
MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
OCCUPATION OF CLERK		OCCUPATION OF REGISTRAR		OCCUPATION OF CITY	
CONTRACTOR		CONTRACTOR		CONTRACTOR	
EDUCATION OF CLERK		EDUCATION OF REGISTRAR		EDUCATION OF CITY	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G243 6-8-59 et

Reg. Dist. No.

05229

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Sparks Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Yeoho Rd. Sparks, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BLAINE B FIELDER				4. DATE OF DEATH Month 5 Day 30 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 1912	
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months 4 Days 46		11. IF UNDER 24 HRS. Hours 46 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY home construction			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Fielder				14. MOTHER'S MAIDEN NAME Martha Trent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. W.W.2-1-9-45-212-14-2889			
17. INFORMANT Alice W. Fielder				Address Benson Mill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF CHEST 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				DATE SIGNED 5-30-59			
EXAMINER'S NAME (Type) PAUL F. GUERIN				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove w.b.		22d. LOCATION (City, town, or county) (State) Herford Md. Parkton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Scott Brooks				ADDRESS 622 York Rd. Tow. 4, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 1959	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneel			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00229

NAME OF DECEASED YOUNG, EDWARD		SEX Male		RACE White		DATE OF BIRTH Nov. 8, 1912		PLACE OF BIRTH U. S. A.	
RESIDENCE 3111 11th St.		OCCUPATION Carpenter		CAUSE OF DEATH Heart Failure		MANNER OF DEATH Natural		SIGNATURE OF EXAMINER [Signature]	
DATE OF DEATH Nov. 8, 1959		TIME OF DEATH 10:00 A.M.		PLACE OF DEATH Home		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]		SIGNATURE OF JURY [Signature]		SIGNATURE OF JURY [Signature]	

1 15255 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05230

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7</u>		c. LENGTH OF STAY IN 1b <u>52</u> Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u> <u>Campfield Rd. - Augsburg Lutheran</u>		d. STREET ADDRESS <u>formerly of 35 Bloomsbury Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>C.</u> Last <u>FINCH</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> , Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30. 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Gottfried C. Schroepfer</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Mary Buschart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mr. Milton Finch - 114 Homeland Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Generalized Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>5 yrs.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15, 1948</u> to <u>5/10, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u> - M.D.		DATE SIGNED <u>4108 Liberty Ate. Balto. 7-11/59</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		<u>4108 Liberty Ate. Balto. 7-11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. Lickner & Sons - Balto</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	
ADDRESS <u>174 W. 17th</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 014 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) 15M 10/57 1 VS A15 (4) 15M 10/57

1 5256

CERTIFICATE OF DEATH

Reg. Dist. No.

05231

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville		c. LENGTH OF STAY IN 1b 1yr3mth11dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		4. DATE OF DEATH May 8 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) butcher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Fisher		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 212-03-4453	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Old myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 5 minutes Many years 1 1/2 yr ago	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 27, 19 58 , to May 8, 19 59 , that I last saw the deceased alive on May 8, 19 59 , and that death occurred at 4:20p. M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		c. catonville 28, Maryland 5/8/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/1959	
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		22d. LOCATION (City, town, or county) (State) BALTO. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Alan J. Carmichael		ADDRESS	
24a. REC'D BY REGISTRAR MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5257

CERTIFICATE OF DEATH

05232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4413 Fitch Ave.		d. STREET ADDRESS 4413 Fitch Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie May Fitch		4. DATE OF DEATH Month May Day 1 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18 1900
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Finney		14. MOTHER'S MAIDEN NAME Minnie Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Fitch		Address 4413 Fitch Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Right Breast, Operation. DUE TO (b) Metastasis to Spine, Ribs, Femur, etc. DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 yrs; 3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 1956 to May 1, 1959 , that I last saw the deceased alive on May 1, 1959 , and that death occurred at A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George W. DeHoff		ADDRESS (Street, city or town, state) 2020 N. Charles St., Baltimore 18, Md.	
PHYSICIAN'S NAME (Type) George W. DeHoff		DATE SIGNED May 2, 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-1959	
22c. NAME OF CEMETERY OR CREMATORY Garden of Faith Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lecahn Funeral Home		24a. REC'D BY REGISTRAR DATE MAY 5 '59	
ADDRESS 7401 Robin Rd.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5258

CERTIFICATE OF DEATH

05233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 52 Catonsville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Stratford Rd.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 307 Stratford Rd. d. STREET ADDRESS 307 Stratford Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWIN FITZGERALD			4. DATE OF DEATH Month May Day 31 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1868		9. AGE (In years last birthday) 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (rtd)			10b. KIND OF BUSINESS OR INDUSTRY Balto. City Pub. School 91		11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME William Fitzgerald			14. MOTHER'S MAIDEN NAME Louisa		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	17. INFORMANT Mrs. Albert R. Mobley Address 307 Stratford Rd. 28		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO Atherosclerotic C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 6 months 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 27, 1959 , to May 31, 1959 , that I last saw the deceased alive on May 27, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE John Aslman		ADDRESS (Street, city or town, state) 5907 Huguenot Oak Ave		DATE SIGNED 6-2-59	
PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/3/59	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Trakner & Sons - Balto		ADDRESS 17		24a. REC'D BY REGISTRAR JUN 3 '59	24b. REGISTRAR'S SIGNATURE Charles S. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

200



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5259

CERTIFICATE OF DEATH

Reg. Dist. No.

05234

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr10mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine First Middle Last		4. DATE OF DEATH May Month Day Year 1 19 69	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Hanigan		14. MOTHER'S MAIDEN NAME Bridget Haddigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 442.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic nephrosclerosis INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30 , 19 59 , to May 1 , 19 59 , that I last saw the deceased alive on May 1 , 19 59 , and that death occurred at 1:55a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-1-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 5/4/59	
22c. NAME OF CEMETERY OR CREMATORY Catholic		22d. LOCATION (City, town, or county) (State) ^F 4300 Old Frederick	
23. FUNERAL DIRECTOR'S SIGNATURE D. J. Fahy & Sons ADDRESS 1318 Light		24a. REC'D BY REGISTRAR MAY 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **45235**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5260 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dearborn 59x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 12 Lamson Ct.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle J. Last FLAHAVEN				4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1931	
				9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Flight Officer Airplane				10b. KIND OF BUSINESS OR INDUSTRY Wisconsin		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leo J. Flahaven				14. MOTHER'S MAIDEN NAME Mary H. Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Mary Flahaven-12 Lanson Court, Dearborn, Mich.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5/12 1959 Hour 1:15 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) St. Paul, Minnesota	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Siskner & Sons - Balto				24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Fennell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

45235

45235

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		10-15-1918	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St.		Farmer		Heart Disease		Natural	
City		County		Hospital		Physician	
Baltimore		Anne Arundel		St. Mary's		Dr. J. Smith	
State		Country		Burial Place		Burial Date	
Maryland		United States		St. Mary's Cemetery		10-18-1918	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
J. Doe		J. Smith		J. Brown		J. White	
Date of Examination		Time of Examination		Place of Examination		Signature of Witness	
10-15-1918		10:00 AM		St. Mary's Hospital		J. Green	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5261

CERTIFICATE OF DEATH

05236

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7757 NORTH POINT CREEK Rd.				d. STREET ADDRESS 7757 NORTH POINT CREEK Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) AUGUSTA		First Middle Last FOERTSCHBECK		4. DATE OF DEATH Month MAY Day 30 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN T. KING				14. MOTHER'S MAIDEN NAME PAULINE SEIBERT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT JOHN F. FOERTSCHBECK, 7757 N. Pt. CR. Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardiovascular disease DUE TO (c) 20 years						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 10, 1958 , to Feb 15, 1959 , that I last saw the deceased alive on May 30, 1959 , and that death occurred at 8:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D St. Balt. 19, Md. DATE SIGNED June 1, 1959							
ACTUAL SIGNATURE John V. Conway				M.D. John V. Conway			
PHYSICIAN'S NAME (Type) John V. Conway							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 3, 1959		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly + Zeiler Inc.				ADDRESS 1901 EASTERN AVE.		24a. REC'D BY REGISTRAR JUNE 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Klaus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5262 CERTIFICATE OF DEATH

Reg. Dist. No.

05237

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Blenheim Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jennie Barrett Ford				4. DATE OF DEATH Month Day Year 5-2-59 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1881	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Barrett				14. MOTHER'S MAIDEN NAME Cecelia Gresh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Roy A. Ford above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Disease 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes. (c) yes INTERVAL BETWEEN ONSET AND DEATH 4 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1938 , to May 2, 1959 that I last saw the deceased alive on May 2, 1959 and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore DATE SIGNED May 4-59							
ACTUAL SIGNATURE Halter M. Hammett							
PHYSICIAN'S NAME (Type) Halter M. Hammett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-5-59	22c. NAME OF CEMETERY OR CREMATORY Poplar Grove	22d. LOCATION (City, town, or county) (State) Cockeysville, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE F. Scott Brooks			ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40333

DEATH CERTIFICATE OF DEATH - 1918

DEATH CERTIFICATE OF DEATH

1918

Bellevue Hospital

Phoenix

1918

Phoenix

Blanche M.

2-2-22

Joanna Barre Ford

28

2-2-1881

Female White

Domestic

None

Married

J.S.A.

Joseph Barre Ford

Goosville

Green

Up

None

Ray A. Ford

Above

Goosville, Md.

Fowler Grove

2-2-22

Burial

552 York Rd., Towson, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5263

CERTIFICATE OF DEATH

Reg. Dist. No.

05238

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - HEBBVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - PASADENA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7409 WINDSOR MILL RD</u>		d. STREET ADDRESS <u>MILL Rd. 02X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>MATTIE</u> Middle <u>CASSANDRA</u> Last <u>FORWOOD</u>		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NICHOLAS SMITH</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DAUGHTER - MRS. LOWREY</u>		Address <u>7409 WINDSOR MILL RD. BALTO. 7, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 12</u> , 19 <u>54</u> , to <u>MAY 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 9</u> , 19 <u>59</u> , and that death occurred at <u>2:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.		ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD. BALTO. 7, MD.</u>	
DATE SIGNED <u>5/9/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5170

CERTIFICATE OF DEATH

05239

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7907 Shore Road				e. STREET ADDRESS 7907 Shore Road			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle RAYMOND Last FREITAG				4. DATE OF DEATH Month May Day 31 , Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Cummins & Hart Constr.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Freitag				14. MOTHER'S MAIDEN NAME Emma Remmers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-2454		17. INFORMANT Regina Kaspar Freitag, wife, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastasis of Sarcooid 138.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 15 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 59 , to May 31 , 19 59 , that I last saw the deceased alive on May 31 , 19 59 , and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1010 North Point Rd Baltimore Md DATE SIGNED 6/2/59 ACTUAL SIGNATURE Morris A. Jacobs M.D. PHYSICIAN'S NAME (Type) MORRIS A. JACOBS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edmund Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.				24a. REC'D BY REGISTRAR DATE JUN 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5264

CERTIFICATE OF DEATH

Reg. Dist. No. 5240

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b <u>1 yr 11 mo. 26 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5737 Dogwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Frizzell</u> Last <u>Frizzell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10th</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15th, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Frizzell</u>		14. MOTHER'S MAIDEN NAME <u>Ballinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emphysema</u> DUE TO (c) <u>Asthma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>several years</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Tuberculosis of the lungs, chronic, inactive</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 9th</u> , 19 <u>59</u> , to <u>May 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>59</u> , and that death occurred at <u>8:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp. Catonsville MD</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADDAUSKAS</u>		DATE SIGNED <u>5/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>	22d. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stantony</u>		ADDRESS <u>6411 Wendenburg Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1910		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARRIAGE		SIGNED BY	
JAN 1 1865		BALTIMORE, MD.		HIGH SCHOOL		METHODIST		MARRIED		JAMES H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
JAN 15 1910		BALTIMORE, MD.		HEART DISEASE		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARRIAGE		SIGNED BY	
JAN 1 1865		BALTIMORE, MD.		HIGH SCHOOL		METHODIST		MARRIED		JAMES H. HARRIS	

1

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

05241

2. DATE
OF
DEATH May 10, 1959

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
 Maryland Balto.

X Baltimore - rural township)

D, STREET ADDRESS (If rural, give location)
1 2203 Smith Avenue

8. DATE OF BIRTH 1-22-1961	9. AGE (In years last birthday)	If Under 1 Year Months: Days	If Under 24 Hours Hours: Min
-------------------------------	------------------------------------	---------------------------------	---------------------------------

Sept 29, 1876	82				
---------------	----	--	--	--	--

11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
--	---

14. MOTHER'S MAIDEN NAME Y. S. H.

Laura J ?

17. INFORMANT	ADDRESS
1. E. H. 11	1

Carroll Dock Emmetsburg Maryland

ONSET AND DEATH
minutes

older the heart disease years

Produce a Home 72-

[Handwritten signature]

old age (82)	
--------------	--

B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?
---	--------------

21F. HOW DID INJURY OCCUR? YES ☐ NO ☐

d from April 11, 1957 to May 1, 1957
deceased alive on May 1, 1957

d on the date stated above. 8 1957,

ADDRESS 34 Wilkes Ave.	23c. DATE SIGNED 5/10/70
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OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
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etery Louisville Carroll Co. Ind.

5. FUNERAL DIRECTOR	ADDRESS

MIL CERTIFICATION

Every item of information soe carefully supplied. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

11830

CERTIFICATE OF DEATH

DATE OF BIRTH
☐ DAY ☐ MONTH ☐ YEAR

DATE OF DEATH
☐ DAY ☐ MONTH ☐ YEAR

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF ARCHIVIST

NAME OF ASSISTANT

CERTIFICATE OF DEATH

05242

Reg. Dist. No.

5266

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. Paradise Av.		d. STREET ADDRESS N. Paradise Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle FULLER Last FULLER		4. DATE OF DEATH Month May Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Snowden		14. MOTHER'S MAIDEN NAME Harriett Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Rosa Adams		Address 537 N. Carey St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease 420.1 DUE TO Grade II Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sclerotic Mellitus left leg amputated 6th year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/31 , 19 46 , to 5/19 , 19 59 , that I last saw the deceased alive on 5/14 , 19 59 , and that death occurred at 4:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eliot W. Johnson		ADDRESS (Street, city or town, state) 3432 7th Avenue DATE SIGNED 5/21/59	
PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON MD		Baltimore 29 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-23-59	22c. NAME OF CEMETERY OR CREMATORY Western Star Cem	22d. LOCATION (City, town, or county) (State) Catonsville, Balto. Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Francis A. Hambley		24a. REC'D BY REGISTRAR DATE MAY 26 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

1924

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
J. J. J. J. J.		M		45		1879		New York		New York		New York		U.S.A.	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
1924		10:00 AM		New York		New York		New York		New York		Heart Disease		Natural	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF NURSE		NAME OF MIDWIFE		NAME OF ATTENDING PHYSICIAN		NAME OF ASSISTANT PHYSICIAN		NAME OF PATHOLOGIST		NAME OF CORONER	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF NURSE		SIGNATURE OF MIDWIFE		SIGNATURE OF ATTENDING PHYSICIAN		SIGNATURE OF ASSISTANT PHYSICIAN		SIGNATURE OF PATHOLOGIST		SIGNATURE OF CORONER	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
1924		10:00 AM		New York		New York		New York		New York		Heart Disease		Natural	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05243

5267

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 15yr11mth10dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> 3160 Naylor Road - S. E. - Washinton, D.		d. STREET ADDRESS 3160 Naylor Road - S. E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minerva Middle Galano Last Galano		4. DATE OF DEATH Month May Day 20 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1909
9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Galano		14. MOTHER'S MAIDEN NAME Louise Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty degeneration and infiltration of myocardium DUE TO (c) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 20, 1959, to May 20, 1959, that I last saw the deceased alive on May 20, 1959, and that death occurred at 10:15p.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED
SPRING GROVE STATE HOSPITAL 5-21-59

ACTUAL SIGNATURE Stella Wachslar M.D.

PHYSICIAN'S NAME (Type) **Stella Wachslar, M. D.** **Catonsville 28, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/59	22c. NAME OF CEMETERY OR CREMATORY Cathedral	22d. LOCATION (City, town, or county) (State) 3300 Frederick Rd
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Lohr		24a. REC'D BY REGISTRAR 1318 Light	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>IMMEDIATE CAUSE OF DEATH [Faint text]</p>	
<p>DATE OF EXAMINATION [Faint text]</p>		<p>TIME OF EXAMINATION [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>DATE OF SIGNATURE [Faint text]</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5268

CERTIFICATE OF DEATH

Reg. Dist. No.

05244

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. LENGTH OF STAY IN 1b <u>51</u> <u>Relay</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1707 Sycamore Ave.</u>		d. STREET ADDRESS <u>1707 Sycamore Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>B.</u> Last <u>GALLAGHER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1922</u>
9. AGE (In years lost birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technical Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Radio</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry G. Gallagher, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Rose P. Bohanan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Drucilla C. Gallagher - 1707 Sycamore Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis and arteriosclerosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>3 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>May 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5 May</u> , 19 <u>59</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. Douglas Lockard</u> M.D. <u>802 Cathedral St</u>			
PHYSICIAN'S NAME (Type) <u>J. Douglas Lockard</u> <u>Baltimore - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Sons - Balto</u> <u>17 Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

CERTIFICATE OF DEATH

2223

See Ord. No.

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1912</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1962</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1962</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	

RECEIVED
MAY 1962

NOTICE TO THE PUBLIC: This certificate is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5269

CERTIFICATE OF DEATH

Reg. Dist. No.

05245

1. PLACE OF DEATH o. COUNTY Baltimore M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland 012 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12X-2 ✓ d. STREET ADDRESS Rural R.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Wilton Middle Atlee Last Gallion		4. DATE OF DEATH Month 5 Day 19 Year 19 59		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/16/91		9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months 5 Days 19 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Henry Gallion James Henry Gallion - deceased						14. MOTHER'S MAIDEN NAME Falitha ?Ross deceased									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no				INFORMANT Rosewood Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of stomach contents complicated by bronchopneumonia DUE TO (b) Malignant tumor of stomach DUE TO (c) Malignant tumor of stomach CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/18/59 , 19____, to 5/19/59 , 19____, that I last saw the deceased 5/19/59 , 19____, and that death occurred at 8:35a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore 14, Md. DATE SIGNED 5/19/59															
ACTUAL SIGNATURE Peter W. Rieckert				ADDRESS 4307 Mainfield Ave											
PHYSICIAN'S NAME (Type) Peter W. Rieckert				DATE 5/19/59											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/21/59		22c. NAME OF CEMETERY OR CREMATORY Rock Run Cemetery				22d. LOCATION (City, town, or county) (State) R.D. Havre de Grace, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring				ADDRESS Tarring Funeral Home				24a. REC'D BY REGISTRAR MAY 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House					

05812

STATE OF OHIO

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W. 363

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THE UNIVERSITY OF CHICAGO

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1921</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

1

RECEIVED
JAN 15 1921
BALTIMORE
STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05248

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graystone Rd.</u>		d. STREET ADDRESS <u>Graystone Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES DAWES GARRETT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9 1905</u> 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Betty Molesworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-38-5707</u>	
17. INFORMANT <u>Mrs. Adeline Garrett, White Hall, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> causes lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Decol. Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-524

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH OFFICE

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
PLACE OF BIRTH [Faint handwritten place]		OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
SIGNATURE OF MEDICAL EXAMINER [Faint handwritten signature]		SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF JURY [Faint handwritten signature]	
CERTIFICATE OF DEATH [Faint handwritten text]		CERTIFICATE OF DEATH [Faint handwritten text]		CERTIFICATE OF DEATH [Faint handwritten text]	

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05249

Reg. Dist. No.

*1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. LENGTH OF STAY (In days) <u>1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2018 Summit</u>				d. STREET ADDRESS <u>2018 Summit</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First Middle Last				4. DATE OF DEATH <u>May 23</u> 19 <u>59</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11 1893</u> Year Month Day	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taylor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Bernard Gigliotti</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Wife</u>		17. INFORMANT <u>Wife</u> Address <u>2018 Summit</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>Old Coronary disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Coronary disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank T. Kasik</u>				DATE SIGNED <u>5/23/59</u>			
EXAMINER'S NAME (Type) <u>FRANK T. KASIK</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>4430 Belair Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank R. Della Noce</u>				24a. REC'D BY REGISTRAR <u>322 S. High St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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322 S. Main St., Portland, Me.
Bureau of Health Statistics
Bureau of Health Statistics
Bureau of Health Statistics

MAINE STATE DEPARTMENT OF HEALTH - BANGOR, ME.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
1922

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5274

CERTIFICATE OF DEATH

05250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home				d. STREET ADDRESS 123 Smithwood Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Fannie Middle Edna Last Gilbert				4. DATE OF DEATH Month May Day 30 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1883		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR: Months 76 Days 76 Hours 76 Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Julius E. Pyles				14. MOTHER'S MAIDEN NAME Frances Aist			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Fred. Koenig Long Island Dr. 29 Address ---			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 8 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1952 to May 30, 1959 , that I last saw the deceased alive on May 29, 1959 , and that death occurred at 1:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St Baltimore 2 Md. DATE SIGNED 6-1-59							
ACTUAL SIGNATURE John A. Nesbitt Jr.		M.D. ---					
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR.		Baltimore 2 Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md. ADDRESS ---				24a. REC'D BY REGISTRAR JUN 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05251

Reg. Dist. No.

5275

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY 69x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flushing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 137-22 Geranium Avenue	
3. NAME OF DECEASED (Type or print) WILLIAM GITTINGER		4. DATE OF DEATH May 12 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1926
9. AGE (in years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Pfizer Co.	
11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William M. Gittinger		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 115-18-4712	
17. INFORMANT Mrs. Dorothy Gittinger		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 1959		20d. INJURY OCCURRED Air over farm	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chase		20f. (City or town) Balto. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) Middle Village N.Y. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. Baltimore, Md.		24a. REC'D BY REGISTRAR MAY 15 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

105251

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

105251

105251

NAME

AGE

SEX

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

Cause of Death

105251

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05252**

1. PLACE OF DEATH a. COUNTY Baltimore 5171 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22			c. LENGTH OF STAY IN lb 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk 22		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3412 Yorkway				d. STREET ADDRESS 3412 Yorkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISY		First DAISY Middle +++ Last GODWIN		4. DATE OF DEATH Month May Day 24th , Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1894	
				9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Grady				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Edward Perry		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 minute 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Jack C. Collins, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/59		22c. NAME OF CEMETERY OR CREMATORY Samaria Cemetery		22d. LOCATION (City, town, or county) (State) Nash Co., North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brink Brinkley				ADDRESS Dundalk, Md.		24a. REC'D BY REGISTRAR MAY 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. JONES		SEX Male		RACE White	
DATE OF BIRTH 11-15-1915		PLACE OF BIRTH Baltimore, Md.		AGE 20 years	
DATE OF DEATH 11-15-1935		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:00 AM	
OCCUPATION Student		CAUSE OF DEATH (To be filled by physician)		MANNER OF DEATH (To be filled by physician)	
SIGNATURE OF PHYSICIAN (To be filled by physician)		SIGNATURE OF MEDICAL EXAMINER (To be filled by examiner)		OFFICIAL SEAL (To be filled by examiner)	
SIGNATURE OF CORONER (To be filled by coroner)		SIGNATURE OF JURY (To be filled by jury)		SIGNATURE OF WITNESSES (To be filled by witnesses)	
SIGNATURE OF DECEASED (To be filled by deceased)		SIGNATURE OF NEXT OF KIN (To be filled by next of kin)		SIGNATURE OF BURIAL SOCIETY (To be filled by burial society)	
SIGNATURE OF FUNERAL HOME (To be filled by funeral home)		SIGNATURE OF CEMETERY (To be filled by cemetery)		SIGNATURE OF INTERMENT (To be filled by interment)	
SIGNATURE OF HEALTH DEPARTMENT (To be filled by health department)		SIGNATURE OF BALTIMORE CITY (To be filled by Baltimore City)		SIGNATURE OF MARYLAND (To be filled by Maryland)	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5276

CERTIFICATE OF DEATH

Reg. Dist. No.

05253

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2109 Maple Ave.		d. STREET ADDRESS 2109 Maple Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR CHESTER GRAMMER		4. DATE OF DEATH Month Day Year May 22 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1887
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY P & B.R. RR.R. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Grammer		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 705-10-9377	
17. INFORMANT Chester Grammer		Address 8346 Bear Creek Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x Congestive heart failure DUE TO (b) Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Prostatic carcinoma, metastatic DUE TO (c) 3 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 10, 1958 to May 22, 1959 , that I last saw the deceased alive on May 22, 1959 , and that death occurred at 3:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9140 St, Balt, Md DATE SIGNED ACTUAL SIGNATURE John V. Conway M.D. PHYSICIAN'S NAME (Type) John V. Conway			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/59	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Parkville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		24a. REC'D BY REGISTRAR MAY 25 '59	
ADDRESS 2112 Dundalk Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05308

CERTIFICATE OF TITLE

5271

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5277
CERTIFICATE OF DEATH

05254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown 16</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Randallstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>Winans Road</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Tabitha</u> Middle <u>May</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15-1874</u>		
9. AGE (In years, last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW. Shopkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Israel Adams</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>George Gray</u>		Address <u>Randallstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c) <u>Arthritis - osteo</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Jan</u> <u>1951</u> , to <u>14 May</u> <u>1959</u> , that I last saw the deceased alive on <u>8 May</u> <u>1959</u> , and that death occurred at <u>11:15 A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Charles H. Williams</u>		M.D. <u>1632 Reisterstown Road</u>		ADDRESS (Street, city or town, state) <u>Pikeville 8 Ind</u>	
DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel</u>	
22d. LOCATION (City, town, or county) (State) <u>Pikeville 8 Ind</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		ADDRESS <u>Pikeville, Ind</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u>					

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George Washington

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Chas. H. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5278

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05255

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Ridge 67x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			d. STREET ADDRESS 285 Ridgewood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle OSCAR Last GRIFFITH			4. DATE OF DEATH Month May Day 12 , Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1897		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director Traffic		10b. KIND OF BUSINESS OR INDUSTRY American Home Products W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas M. Griffith			14. MOTHER'S MAIDEN NAME Mary Eliz. Griffith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes World War I		16. SOCIAL SECURITY NO. 058-10-5326		17. INFORMANT Mrs. Vivian N. Griffith - 285 Ridgewood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash			
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) Chase	(County) Balto. (State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>5/12/59</i>	
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/59	22c. NAME OF CEMETERY OR CREMATORY Bloomfield		22d. LOCATION (City, town, or county) (State) Bloomfield, N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kenna</i>		24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH CERT.

5218

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

45253

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Undertaker: _____

18. Signature of Burial: _____

19. Signature of Cremation: _____

20. Signature of Other: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5279

CERTIFICATE OF DEATH

Reg. Dist. No.

05256

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks, Md. (Belclaire) d. NAME OF HOSPITAL (If not in hospital, give street address) 12 Belclaire Circle				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks, Md. d. STREET ADDRESS 12 Belclaire Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Johanna Ellen Groeninger				4. DATE OF DEATH Month Day Year 5 22 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 27, 1876		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 1 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. O'Brien				14. MOTHER'S MAIDEN NAME Margret Jane O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mary Jane Moore (granddaughter) Address 15 Belclaire Circle			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiac vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 12 H.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-1 , 19 57 , to 5-22 , 19 57 , that I last saw the deceased alive on 5-22 , 19 57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Herbert Mueller Jr. PHYSICIAN'S NAME (Type) C. Herbert Mueller Jr.				ADDRESS (Street, city or town, state) Huefred, Packer P.O. Md DATE SIGNED 5/22/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. ADDRESS 1050 York Rd. Towson				24a. REC'D BY REGISTRAR DATE MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kinner	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		Jan 5, 1928		Memphis, Tenn.		Salesman		Shot by sniper fire		Nashville, Tenn.		10:00 AM		[Signature]		[Signature]	
12. MARITAL STATUS		13. EDUCATION		14. RELIGION		15. SERVICE		16. CITIZENSHIP		17. RACE		18. COLOR		19. HEIGHT		20. WEIGHT		21. HAIR		22. EYES	
Single		High School		Methodist		None		American		White		White		5'10"		175		Brown		Blue	
23. PREVIOUS MARRIAGES		24. PREVIOUS DEATHS		25. PREVIOUS MENTAL ILLNESS		26. PREVIOUS PHYSICAL ILLNESS		27. PREVIOUS SURGERY		28. PREVIOUS DRUGS		29. PREVIOUS ALCOHOL		30. PREVIOUS TOBACCO		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER		37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER		49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER		61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER		73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER		77. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER		85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER		97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER		103. PREVIOUS OTHER		104. PREVIOUS OTHER		105. PREVIOUS OTHER		106. PREVIOUS OTHER		107. PREVIOUS OTHER		108. PREVIOUS OTHER		109. PREVIOUS OTHER		110. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	



TO BE FILLED BY THE REGISTRAR OF DEATHS

1. This certificate is to be filled out by the registrar of deaths in the county where the death occurred.

2. The cause of death should be stated in as many words as possible, and should be as specific as possible.

3. The place of death should be stated as fully as possible.

4. The time of death should be stated as fully as possible.

5. The signature of the registrar should be written in ink.

6. The signature of the deceased should be written in ink.

7. The certificate should be filed in the county where the death occurred.

8. The certificate should be retained for a period of ten years.

9. The certificate should be made available to the public upon request.

10. The certificate should be made available to the courts upon request.

11. The certificate should be made available to the family of the deceased upon request.

12. The certificate should be made available to the insurance company upon request.

13. The certificate should be made available to the medical examiner upon request.

14. The certificate should be made available to the coroner upon request.

15. The certificate should be made available to the police upon request.

16. The certificate should be made available to the sheriff upon request.

17. The certificate should be made available to the justice of the peace upon request.

18. The certificate should be made available to the clerk of the court upon request.

19. The certificate should be made available to the clerk of the county upon request.

20. The certificate should be made available to the clerk of the city upon request.

21. The certificate should be made available to the clerk of the town upon request.

22. The certificate should be made available to the clerk of the village upon request.

23. The certificate should be made available to the clerk of the hamlet upon request.

24. The certificate should be made available to the clerk of the settlement upon request.

25. The certificate should be made available to the clerk of the place upon request.

26. The certificate should be made available to the clerk of the location upon request.

27. The certificate should be made available to the clerk of the spot upon request.

28. The certificate should be made available to the clerk of the point upon request.

29. The certificate should be made available to the clerk of the place upon request.

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97. The certificate should be made available to the clerk of the place upon request.

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100. The certificate should be made available to the clerk of the point upon request.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5280

CERTIFICATE OF DEATH

05257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) 7 A MAPLE DRIVE				d. STREET ADDRESS 7 A MAPLE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FANNIE MAE GROSS				4. DATE OF DEATH Month Day Year MAY 27 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1898		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BOONE, N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB FLETCHER				14. MOTHER'S MAIDEN NAME MARTISHA GREER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 246-36-1514		17. INFORMANT Address MRS. MARY JO SMITH 7 A MAPLE DRIVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno CA of lung 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		
			(State)				
21. I certify that I attended the deceased from 05-25-1959 to 5-27-1959 , that I last saw the deceased alive on 5-27-59 , 19____, and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 805 Fuselage Ave. Balto. 20, Md.							
ACTUAL SIGNATURE M. Rombro M.D.							
PHYSICIAN'S NAME (Type) M. Rombro							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-30-1959		22c. NAME OF CEMETERY OR CREMATORY HINES CEMETERY		22d. LOCATION (City, town, or county) (State) BOONE, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home 7401 Belair Rd				24a. REC'D BY REGISTRAR DATE JUN 1 59		24b. REGISTRAR'S SIGNATURE REGISTRAR'S SIGNATURE	

5281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05258

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster 75 X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 93 Peach Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DORIS Middle ELAINE Last GULICK		4. DATE OF DEATH Month May Day 12 , Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1930
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess		10b. KIND OF BUSINESS OR INDUSTRY Airplane	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME J. Robert Gulick	
14. MOTHER'S MAIDEN NAME Pauline M. Haugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. J. R. Gulick - Blossom Hill, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 1959 Hour XXXX p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	20f. (City or town) (County) (State) Chase Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/59	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	22d. LOCATION (City, town, or county) (State) York, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner & Sons - Balto		24a. REC'D BY REGISTRAR DATE MAY 14 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5281

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08258

FILE NO. 123

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 1, 1950	
Place of Birth		Race		Occupation		Cause of Death	
New York		White		Teacher		Heart Disease	
Residence		Marital Status		Education		Manner of Death	
123 Main St.		Married		High School		Natural	
Date of Birth		Social Security No.		Hospital		Physician	
Jan 1, 1905		123-45-6789		St. Mary's		Dr. Smith	
Time of Death		Place of Death		Signature of Examiner		Signature of Physician	
10:00 AM		Home		[Signature]		[Signature]	
Time of Autopsy		Place of Autopsy		Signature of Coroner		Signature of Medical Examiner	
12:00 PM		St. Mary's		[Signature]		[Signature]	
Time of Burial		Place of Burial		Signature of Minister		Signature of Medical Examiner	
2:00 PM		St. Mary's		[Signature]		[Signature]	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF BALTIMORE, MARYLAND, FOR RECORD.

05260

VS A15 (4)
1SM 10/S7

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

5284

Item 8 Film 243 6-2-59 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05261

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> <i>OVERLEA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO.</i>	c. LENGTH OF STAY IN 1b <i>17 YRS.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OVERLEA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>OVERLEA 5701 EAST AVE.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>PHILIP OR PHILIBERT HARANT</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>22</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1886 MAY 6, 1886</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GROGER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GROGER</i>	
11. BIRTHPLACE (State or foreign country) <i>AUSTRIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN HARANT</i>		14. MOTHER'S MAIDEN NAME <i>THERESA KUBELEK</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>1 KAMILA HARANT 5701 EAST</i>	
17. INFORMANT <i>KAMILA HARANT 5701 EAST</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cancer of stomach</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs?</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-28-</i> , 19 <i>57</i> , to <i>5-22-</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5-21-59</i> , 19 <i>59</i> , and that death occurred at <i>4:30p</i> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1 W. Overlea Ave. Balto. 6 Md.</i> DATE SIGNED <i>5-23-59</i>			
ACTUAL SIGNATURE <i>Richard R. Rigler</i>		M.D. <i>1 W. Overlea Ave. Balto. 6 Md.</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Richard R. Rigler</i>		DATE SIGNED <i>5-23-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>MAY 20-1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MOLY REDEMPTOR</i>		22d. LOCATION (City, town, or county) (State) <i>BELAIR RD MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dippel Bros</i>		ADDRESS <i>7110 BELAIR RD</i>	
24a. REC'D BY REGISTRAR <i>MAY 26 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	

CERTIFICATE OF DEATH

152501

152501

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John Henry		Male		45		Jan 15 1880		New York	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 Main St		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
Jan 20 1925		10:30 AM		10		30		00	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Home		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
Jan 20 1925		10:30 AM		10		30		00	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Home		Carpenter		Heart Disease		Natural		Home	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

VS. A15ME
5M 2/57

5285

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disf. No. 05262

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Athens 49X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 190 West View Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD. Middle M. Last HECKMAN Jr				4. DATE OF DEATH Month May Day 12, Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12. 1932		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Clark County, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold M. Heckman. Sr.				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.		17. INFORMANT Harold M. Heckman Sr. Address 190 West View Dr. Athens, Ga.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash							INTERVAL BETWEEN ONSET AND DEATH
20c. TIME OF INJURY Month, Day, Year 5/15 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/14/59	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May, 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Oconee Cemetery		22d. LOCATION (City, town, or county) (State) Athens, Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.				24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

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5285

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

115203

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various sections.

IDENTIFICATION

NAME: _____
AGE: _____
SEX: _____
RACE: _____
DATE OF BIRTH: _____
PLACE OF BIRTH: _____
RESIDENCE: _____
OCCUPATION: _____

DEATH INFORMATION

DATE OF DEATH: _____
TIME OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____

EXAMINATION

PHYSICAL EXAMINATION: _____
HISTORICAL INFORMATION: _____
LABORATORY TESTS: _____
TOXICOLOGY: _____
AUTOPSY: _____

CERTIFICATION

I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the person named above.

SIGNATURE: _____
TITLE: _____
DATE: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5286

CERTIFICATE OF DEATH

Reg. Dist. No. **05263**

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monkton Road		d. STREET ADDRESS 2709 Boone Street	
3. NAME OF DECEASED (Type or print) Charles Richard First Heisterman Middle Heisterman Last		4. DATE OF DEATH MAY 10 Month 10 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1875
9. AGE (In years birth to day) 83 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-retired		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Augustus Heisterman		14. MOTHER'S MAIDEN NAME Rosa Pindell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-4470	
17. INFORMANT Mrs. Margaret Foster, Hereford, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/18 , 19 59 , to 5/10 , 19 59 ; that I last saw the deceased alive on 2/1/59 , 19 59 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A.M. France		DATE SIGNED 5/10/59	
PHYSICIAN'S NAME (Type) A.M. FRANCE		ADDRESS (Street, city or town, state) PARKTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 13, 1959	
22c. NAME OF CEMETERY OR CREMATORY Govans Presbyterian Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR MAY 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 20 1945		10:30 AM		Home		Dr. J. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

5287

CERTIFICATE OF DEATH

Reg. Dist. No.

05264

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Delray Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emory L. Helm</u> First Middle Last		4. DATE OF DEATH <u>May 28</u> Month Day Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/85</u> 9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Helm</u>		14. MOTHER'S MAIDEN NAME <u>Lila Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5- May Helm</u> INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Pulmonary Emphysema (severe)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cor Pulmonale</u> DUE TO (c) <u>Hypertensive Cardiovascular H. disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>54 years</u> <u>6 months</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> to <u>May 28</u> , 19 <u>59</u> that I last saw the deceased alive on <u>May 27</u> , 19 <u>59</u> , and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1118 St. Paul St - Balto.</u> DATE SIGNED <u>2</u>			
ACTUAL SIGNATURE <u>Wm. Lee Fort</u>		M.D. <u>1118 St. Paul St - Balto.</u>	
PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Lee Fort</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

(1)

(1)



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Weather", "Forecast", and "Air Force" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05265

1. PLACE OF DEATH a. COUNTY BALTO 5288 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Balto		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Balto....Fullerton-Overlea	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 Raspe Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY HERBERT		4. DATE OF DEATH Month Day Year May 21 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Mar 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Retired		10b. KIND OF BUSINESS OR INDUSTRY Produce Market	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Herbert		14. MOTHER'S MAIDEN NAME Mary Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-4708	
17. INFORMANT Frances Herbert (wife)		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Hypertensive Cardiovascular Disease Atherosclerosis Advanced Diabete Mellitus 9 known ten yrs aprox.			
INTERVAL BETWEEN ONSET AND DEATH undet undet			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabete Mellitus 9 known ten yrs aprox.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John C Hyle MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Address		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE SIGNED 5-21-59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05266

5289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1107 Elmridge Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wade Middle Clifton Last Hobbs		4. DATE OF DEATH Month May Day 14 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1907
9. AGE (In years lost birthday) yrs. 51		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Manager		10b. KIND OF BUSINESS OR INDUSTRY Ward Baking Co.	
11. BIRTHPLACE (State or foreign country) Gaithers, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elias C. Hobbs		14. MOTHER'S MAIDEN NAME Margaret A. Hobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret A. Hobbs		Address 1107 Elmridge Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease - Mitral Stenosis DUE TO cardiac arrhythmia fibrillation (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 58 , to 5.14 , 19 59 , that I lost saw the deceased alive on 5-8- , 19 59 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 Chase St Baltimore 2nd DATE SIGNED ACTUAL SIGNATURE Martin L. Steward M.D. MARTIN L. STEWARD, M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/59	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge MD Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Baltimore

Maryland

Baltimore

Baltimore

1107 Elmridge Avenue

1107 Elmridge Avenue

May 14, 1952

Hobbs

Clifton

Wade

Nov. 29, 1907

XX

White

Male

Galihers, Maryland U. S. A.

Personnel Manager Ward Baking Co.

Margaret A. Hobbs

Eliza C. Hobbs

Margaret A. Hobbs 1107 Elmridge Ave.

no

Meadowridge Cemetery Elbridge NM Maryland

5/18/52

Burial

Howard H. Hubbard 1107 Wilkens Avenue

5290

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05267

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BOX # 206 RT. 16 BIRD RIVER RD.		d. STREET ADDRESS BOX # 206 RT. 16 BIRD RIVER RD.	
3. NAME OF DECEASED (Type or print) HERBERT FRANCIS HOCKLEY		4. DATE OF DEATH MAY 23, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 21, 1904
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIELD FOREMAN	
11. BIRTHPLACE (State or foreign country) DUNKIRK, N.Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES HOCKLEY		14. MOTHER'S MAIDEN NAME GRACE LAYTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES W. W. II		16. SOCIAL SECURITY NO. 213-093217	
17. INFORMANT MARIE L. HOCKLEY		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-59	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Giles		24a. REC'D BY REGISTRAR 4015 CONKLING ST BALTO., MD.	
		24b. REGISTRAR'S SIGNATURE DATE MAY 25 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-20

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25-90

FOR STATE
HEALTH DEPT

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE: [illegible]

1

1. I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that the above is a true and correct statement of the facts in the case of the deceased named above, and that the cause of death is as stated above.

2. I further certify that the death of the deceased named above was caused by the disease or injury stated above, and that the death was not caused by any other disease or injury.

3. I further certify that the death of the deceased named above was not caused by any other disease or injury.

4. I further certify that the death of the deceased named above was not caused by any other disease or injury.

5. I further certify that the death of the deceased named above was not caused by any other disease or injury.

6. I further certify that the death of the deceased named above was not caused by any other disease or injury.

7. I further certify that the death of the deceased named above was not caused by any other disease or injury.

8. I further certify that the death of the deceased named above was not caused by any other disease or injury.

9. I further certify that the death of the deceased named above was not caused by any other disease or injury.

10. I further certify that the death of the deceased named above was not caused by any other disease or injury.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5291 CERTIFICATE OF DEATH

05268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7308 Heine Ave. Balto. 6		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County (Rosedale) d. STREET ADDRESS 7308 Heine Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY A HORNBERGER First Middle Last		4. DATE OF DEATH 5/12/59 Month Day Year	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1879 yrs.
9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman 10b. KIND OF BUSINESS OR INDUSTRY Coal Mines 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter Hornberger		14. MOTHER'S MAIDEN NAME Sarah Henninger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 179 10 8567 17. INFORMANT Thamah Zeigenfuse, 7308 Heine Ave. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 , to May 12, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 5:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore 17, Md. DATE SIGNED Arthur S. Kraus PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial		22b. DATE THEREOF 5/15/59	
22c. NAME OF CEMETERY OR CREMATORY Citizens Cemetery		22d. LOCATION (City, town, or county) (State) Lavelle, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
ADDRESS 4107 Wilkens Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Lavelle, Pa.

Citizens Cemetery

5/15/55

Buried

Howard R. Hubbard 1107 Wilkens Ave.

179 10 8567 Thomas Seligman, 7308 Helms Ave.

Sarah Henninger

Peter Henninger

Pennsylvania

Coal Mines

Stationary Fireman

79

May 25, 1879

x

white

Male

HARRY A HENNINGER

5/15/55

7308 Helms Ave

7308 Helms Ave, Balto. 6

Baltimore County (Rosedale)

Baltimore

MD.

Baltimore

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16

5292 CERTIFICATE OF DEATH

Reg. Dist. No.

05269

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Fork Road		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fork		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Baldwin, RD			
3. NAME OF DECEASED (Type or print) First Harry Middle Steven Last Hurline				4. DATE OF DEATH Month May Day 18 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1889	9. AGE (In year lost birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farm		11. BIRTHPLACE (State or foreign country) Phoenix, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Daniel Hurline				14. MOTHER'S MAIDEN NAME Mary Elizabeth Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1910-1913		INFORMANT Mrs. Clara E. Hurline		Address Baldwin Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Prostate DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 1955, to May , 1959, that I last saw the deceased alive on May 18 , 1959, and that death occurred at 1:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 5-19-59							
ACTUAL SIGNATURE William L. Tyson M.D.				PHYSICIAN'S NAME (Type) William L. Tyson Kingsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/1959		22c. NAME OF CEMETERY OR CREMATORY St. Johns Luthern		22d. LOCATION (City, town, or county) (State) Sweet Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Ruff				ADDRESS Jarrettville Md		24a. REC'D BY REGISTRAR MAY 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

00288

CERTIFICATE OF DEATH

3006

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(County)

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5293 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr11mth 12dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Agnes Middle Schleet Last Imfang				4. DATE OF DEATH Month May Day 20 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1873 2	
9. AGE (In years last birthday) 85 3		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Schleet				14. MOTHER'S MAIDEN NAME Elizabeth Newman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 , 19 59 , to May 20 , 19 59 , that I last saw the deceased alive on May 20 , 19 59 , and that death occurred at 2:30a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-20-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		5-23-59		St. Johns Cemetery		Baltimore City	
23. FUNERAL DIRECTOR'S SIGNATURE Edmund J. ...				ADDRESS 23959 Washington Blvd		24a. REC'D BY REGISTRAR MAY 22 59	
				24b. REGISTRAR'S SIGNATURE Charles S. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05271**

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore 5294 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Huntington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Island 69X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			d. STREET ADDRESS 35 Glen Way		
3. NAME OF DECEASED (Type or print) ROBERT ANDREW JACKSON			4. DATE OF DEATH May 12 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1926		9. AGE (In years last birthday) 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Dep't.			10b. KIND OF BUSINESS OR INDUSTRY Beglow & Sanford		11. BIRTHPLACE (State or foreign country) Waterbury, Connicut
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Andrew J. Jackson		
14. MOTHER'S MAIDEN NAME Alma Fitzmurice			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W. 11		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Medelise Jackson- Address same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Airplane crash			
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 1959	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) Chase (County) Balto. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/12/59	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 16, 1959	22c. NAME OF CEMETERY OR CREMATORY New St. Josephs Cem.		22d. LOCATION (City, town, or county) Waterbury Conn. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



THIS STATE
HEALTH DEPT
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100-1-10-1

NAME OF DECEASED: JACOBSON, JACOB
AGE: 45
SEX: M
RACE: W
DATE OF DEATH: 10/12/1912
PLACE OF DEATH: 100-1-10-1
CAUSE OF DEATH: Myocardial infarction
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: J. H. Smith
DATE: 10/12/1912

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05272**

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore 5295 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 54		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 543 Welbrook Road			d. STREET ADDRESS 543 Welbrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) THERESA JANISH First JANISH Middle Silvano Last Silvano			4. DATE OF DEATH May 16 1959 Month May Day 16 Year 1959		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/1895		9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Margaret Silvano, dght, above Address Unknown		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 16 min DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack C Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-18-59	
EXAMINER'S NAME (Type) Jack C Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/19/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
22d. LOCATION (City, town, or county) Baltimore, Md.		24a. REC'D BY REGISTRAR DATE MAY 19 '59			
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

FOR STATE
HEALTH DEPT.



RECEIVED

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
RESIDENCE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05273

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5296 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN lb New York 69x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 29 East 64th Street	
3. NAME OF DECEASED (Type or print) First F Middle JACK Last JEUCK		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1906
9. AGE (in years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY Unknown	
13. FATHER'S NAME Frank J. Jeuck		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 866-09-1180	
17. INFORMANT Shaw Funeral Home - Battle Creek, Mich.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	20f. (City or town) (County) (State) Chase Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		DATE SIGNED 5/12/59	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 5/14/59	22c. NAME OF CEMETERY OR CREMATORY Battle Creek	22d. LOCATION (City, town, or county) (State) Battle Creek, Mich.
23. FUNERAL DIRECTOR'S SIGNATURE Sam. J. Tucker & Sons - Balto		24a. REC'D BY REGISTRAR DATE MAY 14 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1

STATE AND STATE DEPT. OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2288

NEW YORK

NEW YORK

ST. PAUL DISTRICT

MURDER - EXTREME INJURY

AT THE DEPT.

CHARGE

ON NEW YORK

RECEIVED

W. J. Davis, Jr.

DEPT. OF HEALTH - BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5297 CERTIFICATE OF DEATH

Reg. Dist. No. **05274**

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 408 N. Curley ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle DAVIS Last JOHNSON				4. DATE OF DEATH Month 5 Day 11 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892 5-15-1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Johnson				14. MOTHER'S MAIDEN NAME Anne McCoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO cavitary (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. cardiac insuff. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 3-10 , 19 59 , to 5-11 , 19 59 , that I last saw the deceased alive on 5-11 , 19 59 , and that death occurred at 7:41 P. M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE William Newcomer				M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.				Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5.14.59		New-Cathedral		Edmondson Ave	
23. FUNERAL DIRECTOR'S SIGNATURE Leah Cook Patterson				ADDRESS		24a. REC'D BY REGISTRAR MAY 14 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18-21 Film 244 6-30-59 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 5298 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Howard Hospital				d. STREET ADDRESS 1118 N. Monroe Street			
3. NAME OF DECEASED (Type or print) First KELLY Middle JOHNSON Last JOHNSON				4. DATE OF DEATH Month May Day 30 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1920	
9. AGE (in years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 3 Days 10		IF UNDER 24 HRS. Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Va				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Lee Johnson				14. MOTHER'S MAIDEN NAME Clarbie Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W 1111		17. INFORMANT Mr Jones - 1118 N. Monroe St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive subdural hemorrhage, right and cerebral contusions DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck on head during altercation			
20c. TIME OF INJURY Hour 11 P. M. 5/26/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Baltimore (County) Baltimore (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Md		22d. LOCATION (City, town, or county) (State) Baltimore md	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson				ADDRESS 1600 Stanton Ave		24a. REC'D BY REGISTRAR JUN 5 1959	
24b. REGISTRAR'S SIGNATURE William D. Hanna				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5299 CERTIFICATE OF DEATH

05275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
3. NAME OF DECEASED (Type or print) First Howard Middle M. Last Jones		4. DATE OF DEATH Month May Day 16 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seaman Chief Engineer		10b. KIND OF BUSINESS OR INDUSTRY Bull line	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Jones		14. MOTHER'S MAIDEN NAME Maggie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and shock 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Volvulus of the descending colon DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis - Senility		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21 1959 to May 16, 1959 , that I last saw the deceased alive on May 16, 1959 , and that death occurred on May 16, 1959 at 4:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-18-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-20-59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1207 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAY 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
MAY 10 1910
MAY 10 1910
MAY 10 1910

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1 1865		Boston, Mass.		Boston, Mass.		Heart Disease		10:30 AM		City of Boston		J. A. Smith		W. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Teacher		Yes		No		No		No		Heart Disease		10:30 AM		City of Boston		J. A. Smith		W. B. Jones		J. C. Brown	
Date of Death		Place of Death		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner	
May 10 1910		City of Boston		Heart Disease		10:30 AM		City of Boston		J. A. Smith		W. B. Jones		J. C. Brown		J. C. Brown		J. C. Brown		J. C. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05277

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>5300</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>				c. LENGTH OF STAY IN 1b <u>53</u> <u>Dundalk</u> <u>Baltimore</u> <u>22</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Disp.</u>				e. STREET ADDRESS <u>3003 Dunglew Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clyde</u> <u>Norman</u> <u>Kalkreuth</u>				4. DATE OF DEATH <u>May</u> <u>3</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-26-06</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacists</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Paul L. Kalkreuth</u>				14. MOTHER'S MAIDEN NAME <u>Lula Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-07-6211</u>		17. INFORMANT <u>Minnie Kalkreuth</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley</u> ADDRESS <u>Dundalk 22</u>				24a. REC'D BY REGISTRAR <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-277

1. NAME OF DECEASED John Doe		2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		3. AGE 45	
4. OCCUPATION Teacher		5. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		6. PLACE OF BIRTH MD	
7. PLACE OF DEATH Home		8. DATE OF DEATH 10-1-1918		9. TIME OF DEATH 10:00 AM	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		12. SIGNATURE OF EXAMINER J. H. Smith	
13. SIGNATURE OF WITNESS W. B. Jones		14. SIGNATURE OF CORONER C. D. Brown		15. SIGNATURE OF JURY None	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE HEALTH DEPARTMENT, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICE IN THE CITY OR TOWN WHERE THE DECEASED RESIDES.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5302

CERTIFICATE OF DEATH

Reg. Dist. No.

05279

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Hessie Last Kennard		4. DATE OF DEATH Month May Day 25 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 3/6/93
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland (Chestertown)	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W. W. I	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 18 , 1959, to May 25 , 1959, that I last saw the deceased alive on May 25 , 1959, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-25-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/29/1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Edsworth Annacast		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
ADDRESS 4600 Liberty Heights Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

5303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05280

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Middle River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn L. Martin Co. Eastern Ave.</u>		d. STREET ADDRESS <u>20 Left Aileron St. Aero Acres</u>	
3. NAME OF DECEASED (Type or print) <u>George B. King</u>		4. DATE OF DEATH <u>May 20, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1923</u>
9. AGE (in years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin G. King</u>		14. MOTHER'S MAIDEN NAME <u>Pauline McCauley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>220-12-9642</u>	
17. INFORMANT <u>Mrs. Jeanette H. King</u>		Address <u>20 Left Aileron St. 20</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns over</u> <u>916.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Entire Body =</u> (c) <u>Entire Body =</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in explosion of clay flint at Anglin Plant</u>	
20c. TIME OF INJURY <u>8:45 a.m. 5/21/59</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>Belair Memorial Co.</u>		20f. (City or town) <u>Middle River</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/21/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) <u>Belair, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. J. J. J.</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

5304

05281

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Parkdale (Oakdale) 69X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkdale (Oakdale) 69X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS Idle Hour Blvd.			
3. NAME OF DECEASED (Type or print) First KENNISH Middle C Last KINKADE				4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec, 24, 1896		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research		10b. KIND OF BUSINESS OR INDUSTRY Shell Oil Co		11. BIRTHPLACE (State or foreign country) Grundy Co., Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Kinkade				14. MOTHER'S MAIDEN NAME Minta Neff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Haas Funeral Home, Bethany, Missouri			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5/12 1959 Hour 5:15 P. M.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) Chase	(County) Balto.	(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 5/12/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORY Willis Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Brimson, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE Charles E. Farnham	

10081

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
5304

STATE OF MASSACHUSETTS
COUNTY OF

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		10/15/1918		Boston, Mass.	
Cause of Death		Disease		Injury		Poison		Other	
Tuberculosis		Pneumonia		Fracture of skull		Alcohol		None	
Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Occupation	
Pneumonia		Tuberculosis		Alcohol		Accident		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Juror		Signature of Witness	
J. A. Smith		D. E. Jones		W. B. Brown		C. F. Green		H. K. White	
Date		Time		Place		Manner		Occupation	
10/15/1918		10:00 AM		Boston, Mass.		Accident		None	

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
5304

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

5305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15282

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>BALTO.</u>		c. LENGTH OF STAY IN 1b <u>3 YOI - 4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GLENN L. MARTIN CO.</u>		d. STREET ADDRESS <u>1002 S. HENWOOD AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANK KRAWCZYK</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 9, 1934</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GLEN L. MARTIN</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FELIX KRAWCZYK</u>		14. MOTHER'S MAIDEN NAME <u>ANASTASIA SIERACKA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>MOREAN</u>		16. SOCIAL SECURITY NO. <u>213-30-7208</u>	
17. INFORMANT <u>CASIMIR KRAWCZYK</u>		Address <u>815 LOALAN - 22 AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd + 4th° Burns over entire body -</u> 916.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>body -</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Burned to death in amphetamine cleaning fluid (Explosion)</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>8:40 a.m. 5/29/59</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>C.E. MONTAGUE</u>	20f. (City or town) (County) (State) <u>Middle River - 20 Baltimore</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL MAY 23/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		22d. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mar. Siolkowski</u>		24a. RECEIVED BY REGISTRAR <u>5/29/59</u>	
ADDRESS <u>1000 S. KENWOOD AVE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5183

CERTIFICATE OF DEATH

Reg. Dist. No. **05283**

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN lb <u>51 1/2 months 27</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2509 Gehb Avenue</u>				d. STREET ADDRESS <u>2509 Gehb Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Adam A. Kreis</u>				4. DATE OF DEATH Month Day Year <u>May 9th 1959</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1884</u>			
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Acc. American Oil Co.</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>212-01-7338</u>		INFORMANT Address <u>Mr. Leo J. Quinn, 2509 Gehb Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X arrested Pulmonary Tb.</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Sept 12, 1957</u> to <u>May 9, 1959</u> that I last saw the deceased alive on <u>May 8, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Albert Scagnetti</u> M.D. <u>1729 W Lombard ST</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>May 11 1959</u>					
PHYSICIAN'S NAME (Type) <u>ALBERT SCAGNETTI</u> <u>Baltimore Md.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>5/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11523

CERTIFICATE OF DEATH

11523

Baltimore

Baltimore

11523

2007 State Revenue

2007 State Revenue

2007 State Revenue

2007 State Revenue

Baltimore, Maryland

Baltimore, Maryland

2007 State Revenue

2007 State Revenue

2007 State Revenue

2007 State Revenue

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2007 State Revenue

2007 State Revenue

2007 State Revenue

2007 State Revenue

2007 State Revenue

2007 State Revenue

2007 State Revenue

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5306 CERTIFICATE OF DEATH

Reg. Dist. No. 05284

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE CITY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland			c. LENGTH OF STAY IN 1b 6 months		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital			d. STREET ADDRESS 1105 So. ROBINSON ST		
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE E KURTZ SR.			4. DATE OF DEATH Month Day Year 5 29 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/11/1900		9. AGE (In years last birthday) yrs. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE CLERK GOODWILL IND.			10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAMUEL KURTZ			14. MOTHER'S MAIDEN NAME NOT KNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-01-5241		
			17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Diffuse Hepatic Necrosis 580X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary Tuberculosis					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 5/29 , 19 59 , to 5/29 , 19 59 , that I last saw the deceased alive on 5/29 , 19 59 , and that death occurred at 8:52 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE William Newcomer			ADDRESS (Street, city or town, state) Mt. Wilson, Maryland		
PHYSICIAN'S NAME (Type) William Newcomer, M.D.			DATE SIGNED Superintendent		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/1/59	22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		22d. LOCATION (City, town, or county) (State) BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE Clarence F. Hoffmann			24a. REC'D BY REGISTRAR 3218 HUDSON ST.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES K. KIRBY		45		M		W		C	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1103 S. 1st St. Baltimore, Md.		11-1-1918		10:30 AM		Home		Heart Disease	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
Clerk		High School		Married		Single		Married	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
11-1-1918		Baltimore, Md.		11-1-1918		Home		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNED	
11-1-1918		Home		Heart Disease		Natural		J. H. Smith, M.D.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNED	
11-1-1918		Home		Heart Disease		Natural		J. H. Smith, M.D.	

5307 CERTIFICATE OF DEATH

05285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALDWIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALDWIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS BALDWIN MILL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lee Jackson Kyle First Middle Last		4. DATE OF DEATH May 28 1959 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OTHER FARMS	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES KYLE		14. MOTHER'S MAIDEN NAME ANNIE BYRD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-18-4448	
17. INFORMANT MRS. KATIE I. KYLE Address BALDWIN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Arterio sclerotic (c) CVI			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial insufficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 19 58 , to May , 19 59 , that I last saw the deceased alive on May 24 , 19 59 , and that death occurred at 6 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Tyson M.D.		ADDRESS (Street, city or town, state) Kingsville, Md DATE SIGNED 5-28-59	
PHYSICIAN'S NAME (Type) William A. Tyson			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/31/59	22c. NAME OF CEMETERY OR CREMATORY FORK METHODIST CHURCH	22d. LOCATION (City, town, or county) (State) FORK MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE JOHN BURNS SONS ADDRESS TOWSON MARYLAND		24a. REC'D BY REGISTRAR JUN 1 59 DATE	
		24b. REGISTRAR'S SIGNATURE Robert S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 VS A15 (4) 15M 10/57 050 05286 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY **Baltimore** MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Fort Howard** c. LENGTH OF STAY IN 1b **12 Days** d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Veterans Administration Hospital** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE **Maryland** b. COUNTY **Baltimore** c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore** d. STREET ADDRESS **5 German Hill Road** 3. NAME OF DECEASED (Type or print) **LAST ~~XXX~~ LAYDEN Middle FIRST ~~XXX~~ ALPHONSO** 4. DATE OF DEATH Month **MAY** Day **22** Year **1959** 5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **4/14/91** 9. AGE (In years last birthday) yrs. **68** IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Machinist** 10b. KIND OF BUSINESS OR INDUSTRY **Winfall, North Carolina** 11. BIRTHPLACE (State or foreign country) **U.S.A.** 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME **JAMES LAYDEN** 14. MOTHER'S MAIDEN NAME **MARY JORDAN** 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **Yes** (If yes, give war or dates of service) **WW I** 16. SOCIAL SECURITY NO. **218-18-6948** 17. INFORMANT **Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.** Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **ARTERIOSCLEROTIC HEART DISEASE** **420.0** DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **RENAL FAILURE, ETIOLOGY UNKNOWN** 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. **VA 19** 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from **May 10**, 19**59**, to **May 22**, 19**59**, and that death occurred at **1:25 PM**, from the causes and on the date stated above. ADDRESS (Street, city or town, state) **VAH, FORT HOWARD, MARYLAND** DATE SIGNED **5/22/59** ACTUAL SIGNATURE **L. Bruce Smith** M.D. **VAH, FORT HOWARD, MARYLAND** PHYSICIAN'S NAME (Type) **L. BRUCE SMITH, M.D.** **VAH, FORT HOWARD, MARYLAND** 22a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 22b. DATE THEREOF **5-23-1959** 22c. NAME OF CEMETERY OR CREMATORY **LAYDEN FAMILY CEMETERY** 22d. LOCATION (City, town, or county) (State) **ELVIDERE, NORTH CAROLINA** 23. FUNERAL DIRECTOR'S SIGNATURE **Wm. Cook, Inc., 1217 St. Paul St., Balto.** ADDRESS **WATFORD FUNERAL HOME, HERTFORD, NORTH CAROLINA** 24b. REGISTRAR'S SIGNATURE **Arthur S. Hana** 24c. REC'D BY REGISTRAR **MAI 25 59** DATE

5309 CERTIFICATE OF DEATH

Reg. Dist. No.

05287

1. PLACE OF DEATH a. COUNTY 1026 Essex Ave. Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE 1026 Essex Ave. Balto. Co. 21			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. LENGTH OF STAY IN 1b 50yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1026 Essex Ave. 21			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last William Edward Leary Sr.				4. DATE OF DEATH Month Day Year May 30, 1959 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. Edward Leary				14. MOTHER'S MAIDEN NAME Catherine Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT Address Edward O. Leary, 1026 Essex Ave. 21			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191.2 METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 3 EPITELIOMA OF LEFT EAR DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO-SCLEROTIC HEART DISEASE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17/53 , 19____, to 5/30/59 , 19____, that I last saw the deceased alive on 5/29/59 , 19____, and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Miceli		M.D. 108 S. TAYLOR AVE		DATE SIGNED 6/1/59			
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D. BALTO. 21, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Hurwighans				ADDRESS 2024 Orleans St. 31		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3001 CERTIFICATE OF DEATH

See last page

<p>1. Name of deceased: JOHN J. BROWN</p>		<p>2. Date of birth: 1901</p>	
<p>3. Sex: Male</p>		<p>4. Race: White</p>	
<p>5. Usual residence: 1000 North Ave., Baltimore, Md.</p>		<p>6. Date of death: June 1, 1950</p>	
<p>7. Cause of death: Myocardial Infarction</p>		<p>8. Place of death: Home</p>	
<p>9. Signature of physician: Dr. J. H. Smith</p>		<p>10. Signature of registrar: John J. Brown</p>	
<p>11. Date of registration: June 1, 1950</p>		<p>12. Registrar's office: Baltimore, Md.</p>	

5310 CERTIFICATE OF DEATH

Reg. Dist. No. 05288

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN lb <u>8 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Levin</u> Last <u>Levin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/00</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC LEVIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY NADISCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Rosewood Records, Owings Mills, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.0 DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO <u>Bilateral pneumonia</u> (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis apertus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-29</u> , 1959, to <u>5-30</u> , 1959, that I last saw the deceased alive on <u>May 30, 1959</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Proprietary</u>		ADDRESS (Street, city or town, state) <u>Rosewood State Tr. School</u> DATE SIGNED <u>7/6/59</u>	
PHYSICIAN'S NAME (Type) <u>J. VASCONCELLOS</u>		<u>Owings Mills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Canton Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

5810 CERTIFICATE OF DEATH

00388

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to contain details about a death certificate, including names, dates, and locations.]

5311 CERTIFICATE OF DEATH

Reg. Dist. No. 05289

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Professional House</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Levin</u> Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sholom</u>		14. MOTHER'S MAIDEN NAME <u>Bluma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Benjamin Levin - same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Cancer of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> to <u>May 7</u> , 19 <u>59</u> that I lost saw the deceased alive on <u>May 7</u> , 19 <u>59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>my 7195</u> (DATE SIGNED) ACTUAL SIGNATURE <u>Joseph B Gross</u> M.D. <u>6911 Park Heights Ave Baltimore</u> PHYSICIAN'S NAME (Type) <u>Joseph B Gross</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-8-59</u>	<u>Hebrew Friendship</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10324

5811

NOB 11/11/11

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5312 CERTIFICATE OF DEATH

Reg. Dist. No.

05290

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3Y01-4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>House in Pines</i>				d. STREET ADDRESS <i>5332 Winner Ave</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Isaac Lipsitz</i>				4. DATE OF DEATH Month Day Year <i>5-28-1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. <i>75</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Not Known</i>				14. MOTHER'S MAIDEN NAME <i>Not Known</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i>		Address <i>Benjamin Lipsitz -</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350x Pericardial Embolus</i> DUE TO <i>Myocardial Infarction CVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>10 yr.</i> <i>12 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 26, 1959</i> to <i>May 28, 1959</i> that I last saw the deceased alive on <i>May 26, 1959</i> , and that death occurred at <i>7:45 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Reverend Kellner</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>3700 Peach Heights Ave Baltimore, MD</i>					
FURNAL DIRECTOR'S NAME (Type) <i>LESTER N. KOLMAN, M.D.</i>		<i>Baltimore, MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-29-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hebrew Young Men</i>		22d. LOCATION (City, town, or county) (State) <i>Balto MD</i>	
23. FURNAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>				ADDRESS <i>2100 Canton Place</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 1 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05291

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5313 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Union		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roselle Park 67X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			d. STREET ADDRESS 215 Sheridan Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle Last LOGAN			4. DATE OF DEATH Month May Day 12 , Year 1959		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11 1918		9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Traffic Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Bedding Mfgng		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Logan			14. MOTHER'S MAIDEN NAME Euphrenia Greenhill		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World 11		16. SOCIAL SECURITY NO. 139-10-8454		17. INFORMANT Address Mrs. Hennrietta Logan As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash			
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 1959 Hour 5:15 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	
				20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles O'Donnell</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF May 14 1959		22c. NAME OF CEMETERY OR CREMATORY Graceland Memorial Park	
				22d. LOCATION (City, town, or county) (State) Kenilworth N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Dickner + Sons</i> <i>Arch + Regina are</i>			24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kane</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05801

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE STATE
HEALTH DEPT

2313

Form with multiple sections for medical examination, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05292**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 5314 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lathams 69x-3 d. STREET ADDRESS 4 West Glenwood Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle H Last MAGGS		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1897
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consulting Engineer	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mark H. Maggs		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes World War No. 1 -073-20-9484		16. SOCIAL SECURITY NO. 484	
17. INFORMANT Mrs. Hilda Maggs - 4 W. Glenwood Dr.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 861x	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash		20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 19 59	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	
20f. (City or town) Chase (County) Balto. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/59	
22c. NAME OF CEMETERY OR CREMATORY Memorys Garden		22d. LOCATION (City, town, or county) (State) Colonie, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons - Balto		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5315

CERTIFICATE OF DEATH

05293

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	c. LENGTH OF STAY IN <u>40 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2827 - A Cub Hill</u>		d. STREET ADDRESS <u>2827 - A Cub Hill</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Anna Magness</u>		4. DATE OF DEATH Month Day Year <u>May 26 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry P. Becker</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Beimler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Son,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure</u> DUE TO <u>Arterioscl. Hypertensive Card. Vasc. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5+ yrs.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Asthmatic Bronchitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1955</u> , to <u>May 26 1959</u> , that I last saw the deceased alive on <u>May 26 1959</u> , and that death occurred at <u>308</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Harford Rd Baltimore 14 Md.</u> DATE SIGNED <u>5/26/59</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 29 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lillian Funeral Home</u> ADDRESS <u>7401 Odian Rd</u>		24a. REC'D BY REGISTRAR <u>MAY 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

1 Item 7, Film G242,5-15-59, mmd 5316 05294 Reg. Dist. No. 1 514 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 514 VS A15 (4) 15M 10/57

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23yr6mth3dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dora Middle Phillips Last Mann		4. DATE OF DEATH Month May Day 9 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland U.S.A.	
13. FATHER'S NAME George Phillips		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration (c) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 yr 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis chronic colitis urinary retention		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4, 1959 , to May 9, 1959 , that I last saw the deceased alive on May 8, 1959 , and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Bruno RADAUSKAS		DATE SIGNED 5/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS Funeral Home	
24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

DEATH CERTIFICATE

REG. CH. 11

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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5317

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05295

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Seaford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b LONG ISLAND - Wantagh 67X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS Brook Lane 2015 Brookland	
3. NAME OF DECEASED (Type or print) First THOMAS Middle MANNIX Last MANNIX		4. DATE OF DEATH Month May Day 12 , Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6, 1922
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Regal Textile Corp	
11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Mannix		14. MOTHER'S MAIDEN NAME Delia McAllen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Wantagh-Abbey Funeral Home - Wantagh, L. I.		Address N. Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/13/59	
22c. NAME OF CEMETERY OR CREMATORY -		22d. LOCATION (City, town, or county) (State) Wantagh, L. I., N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 8 Film G243 5-25-59 et

5318

CERTIFICATE OF DEATH

05296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>2 WKS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>905 Chestwood Rd</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 AR BUT US</u> d. STREET ADDRESS <u>1704 TAYLOR AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>M. Marks</u> Middle <u>M. Marks</u> Last 4. DATE OF DEATH <u>May 17</u> Month <u>May</u> Day <u>17</u> Year <u>1959</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1893</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GRANITE MNL</u> 11. BIRTHPLACE (State or foreign country) <u>GRANITE MNL</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ALBERT WHEAT</u>		14. MOTHER'S MAIDEN NAME <u>JANNIE MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>JOSEPH FRANKLIN MARKS</u> Address <u>CATONSVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, recurrent</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH 6 WKS.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/30</u> , 19 <u>59</u> , to <u>5/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/14</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D. <u>5305 East Drive</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u> <u>Baltimore - 27, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>20 May 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Houder Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Art & B. M. Walters</u> ADDRESS <u>Stricker St</u>		24a. REC'D BY REGISTRAR <u>MAY 21 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

CERTIFICATE OF DEATH

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THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

AND HUMAN RESOURCES

OFFICE OF THE REGISTRAR

STATE OF MARYLAND

DEPARTMENT OF HEALTH

AND HUMAN RESOURCES

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OFFICE OF THE REGISTRAR

STATE OF MARYLAND

1 
FOR STATE
HEALTH DEPT.

5319

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05297

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bentley Springs</u>		c. LENGTH OF STAY IN 1b <u>????</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bentley Springs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eagle Mill Rd.</u>				d. STREET ADDRESS <u>Eagle Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE Belle MARSH</u>				4. DATE OF DEATH <u>MAY 12 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Tillman</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Schneider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Burton A. Marsh</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/13/59</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson4, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>	

5319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

113293

<p>NAME OF DECEASED John T. Talbot</p>		<p>RESIDENCE 111 N. E. 1st St.</p>	
<p>DATE OF DEATH 1-1-1904</p>		<p>PLACE OF DEATH Home</p>	
<p>AGE 45</p>		<p>SEX Male</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>MANNER OF DEATH None</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION None</p>	
<p>RELIGION None</p>		<p>ETHNIC ORIGIN None</p>	
<p>PREVIOUS ILLNESS None</p>		<p>PREVIOUS SURGERY None</p>	
<p>SMOKING HABIT None</p>		<p>ALCOHOLIC HABIT None</p>	
<p>DIETARY HABIT None</p>		<p>EXERCISE HABIT None</p>	
<p>TEMPERATURE None</p>		<p>PULSE None</p>	
<p>BLOOD PRESSURE None</p>		<p>RESPIRATORY None</p>	
<p>NEURAL None</p>		<p>SKIN None</p>	
<p>TEETH None</p>		<p>HAIR None</p>	
<p>NOSE None</p>		<p>THROAT None</p>	
<p>STOMACH None</p>		<p>INTESTINES None</p>	
<p>BLADDER None</p>		<p>GENITALS None</p>	
<p>PROSTATE None</p>		<p>UTERUS None</p>	
<p>VAGINA None</p>		<p>PERINEUM None</p>	
<p>RECTUM None</p>		<p>ANUS None</p>	
<p>SPINAL CORD None</p>		<p>BRAIN None</p>	
<p>HEART None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
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<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</p>	
<p>BRAIN None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
<p>BLADDER None</p>		<p>PROSTATE None</p>	
<p>UTERUS None</p>		<p>VAGINA None</p>	
<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</p>	
<p>BRAIN None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
<p>BLADDER None</p>		<p>PROSTATE None</p>	
<p>UTERUS None</p>		<p>VAGINA None</p>	
<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</p>	
<p>BRAIN None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
<p>BLADDER None</p>		<p>PROSTATE None</p>	
<p>UTERUS None</p>		<p>VAGINA None</p>	
<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</p>	
<p>BRAIN None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
<p>BLADDER None</p>		<p>PROSTATE None</p>	
<p>UTERUS None</p>		<p>VAGINA None</p>	
<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</p>	
<p>BRAIN None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
<p>BLADDER None</p>		<p>PROSTATE None</p>	
<p>UTERUS None</p>		<p>VAGINA None</p>	
<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</p>	
<p>BRAIN None</p>		<p>LUNGS None</p>	
<p>LIVER None</p>		<p>SPLEEN None</p>	
<p>PANCREAS None</p>		<p>KIDNEYS None</p>	
<p>BLADDER None</p>		<p>PROSTATE None</p>	
<p>UTERUS None</p>		<p>VAGINA None</p>	
<p>PERINEUM None</p>		<p>RECTUM None</p>	
<p>ANUS None</p>		<p>SPINAL CORD None</</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5320

CERTIFICATE OF DEATH

05298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 333 Laurel Avenue - Laurel Md. 16412			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 333 Laurel Avenue			
3. NAME OF DECEASED (Type or print) Olga First Middle Last				4. DATE OF DEATH May 19 1959 Month Day Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1883		9. AGE (In years last birthday) yrs. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? Sweden <input checked="" type="checkbox"/>	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records : SPRING GROVE STATE HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 1959 , to May 19 1959 , that I last saw the deceased alive on May 19 1959 , and that death occurred at 10:20a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-19-59			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 23, 1959		22c. NAME OF CEMETERY OR CREMATORY FOREST HILLS		22d. LOCATION (City, town, or county) (State) SOMMERTAN PA.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE MAY 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

5321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 12 Film G243 6-5-59 et
1000 0 Film G244 7-1-59 et

CERTIFICATE OF DEATH

05299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>CATONSVILLE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> <u>402 OLD VIEW COURT</u> <u>52 CATONSVILLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>MARUT</u> Last <u>MARUT</u>		4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unk</u>		14. MOTHER'S MAIDEN NAME <u>Unk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SR. MARY LAURENTIA - HAMBURG ARE</u>		Address <u>Catonville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HTCVD</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>20+ yrs</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10, 1959</u> to <u>5/25, 1959</u> , that I last saw the deceased alive on <u>5/25, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Krator F. King</u>		ADDRESS (Street, city or town, state) <u>715 Frederick Rd</u>	
PHYSICIAN'S NAME (Type) <u>Fred W. Ozogowski</u>		DATE SIGNED <u>5/25/59</u>	
22a. BURIAL-CREATION, REMOVAL (Specify) <u>5-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	
22b. DATE THEREOF		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozogowski</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 27 1959</u>	
ADDRESS <u>1930 Eastern Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5322

CERTIFICATE OF DEATH

Reg. Dist. No.

05300

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 1329 NORTH BOND ST			
3. NAME OF DECEASED (Type or print) First FRANK Middle MATTHEWS Last				4. DATE OF DEATH Month MAY Day 15 Year 1959			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 12, 1920 39 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIE MATTHEWS				14. MOTHER'S MAIDEN NAME MINNIE STARKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-18-0527		17. INFORMANT Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest (following Chest Surgery) DUE TO Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 36 hrs 7 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/10 , 19 59 , to 5-15 , 19 59 , that I last saw the deceased alive on 5-15 , 19 59 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William Newcomer M.D. Mt. Wilson, Maryland ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		5/18/59		St. Elmyr Cem.		C.B. Brantley Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. 512 Carroll				24a. REC'D BY REGISTRAR DATE MAY 18 59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323

CERTIFICATE OF DEATH

Reg. Dist. No.

05301

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		d. STREET ADDRESS 1217 Stella Dr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1217 Stella Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEVEN Middle H. Last MATTHEWS		4. DATE OF DEATH Month 5 Day 11 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-57
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Matthews		14. MOTHER'S MAIDEN NAME Ellen Jane Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Harry Matthews, 1217 Stella Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute upper respiratory infection DUE TO Cerebral palsy - athetoid type Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 475x (c) 475x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 475x			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/7 , 19 57 to 5/11 , 19 57 , that I last saw the deceased alive on 6/5 , 19 58 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward L. Frey, Jr.		ADDRESS (Street, city or town, state) 4605 Edmondson Ave. Balto. 29, Md.	
DATE SIGNED 5/12/59		M.D. 5/12/59	
PHYSICIAN'S NAME (Type) EDWARD L. FREY, JR.		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/59	
22c. NAME OF CEMETERY OR CREMATORY St Johns Cem.		22d. LOCATION (City, town, or county) (State) Ellicott City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave		24a. REC'D BY REGISTRAR MAY 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAY 15 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5184 CERTIFICATE OF DEATH

Reg. Dist. No.

05302

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe 51</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5555 Link Ave.</u>		d. STREET ADDRESS <u>5555 Link Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Mauer</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Install</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Storm Window</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otto Mauer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-034047</u>	
17. INFORMANT Address <u>Eva B. Mauer 5555 Link Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Occlusion</u> DUE TO (b) <u>to Myocardial Infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>May 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/4</u> , 19 <u>59</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Bealey</u> M.D.		ADDRESS (Street, city or town, state) <u>States Hook, Md</u> DATE SIGNED <u>5/5/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery Baltimore, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambrose, Inc. 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

105 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5324

CERTIFICATE OF DEATH

05303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>19 Pelczar Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Maxwell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20 1913</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolteacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>W.H. Carson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Dill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>136-18-5605</u>	
17. INFORMANT <u>Mr. Seibert Maxwell</u>		Address <u>As Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BREAST</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 MO.</u> <u>4 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR. 16, 1949</u> , to <u>MAY 17, 1959</u> , that I last saw the deceased alive on <u>MAY 17, 1959</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u>		ADDRESS (Street, city or town, state) <u>108 S. TAYLOR AVE</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D. BALTIMORE 21, MD.</u>		DATE SIGNED <u>5/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Liskner & Son</u> <u>North & Penna Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1934

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

1934

REG. DIV. 112

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>May 10 1934</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>RESIDENCE <i>123 Main St., Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>DATE OF BURIAL <i>May 12 1934</i></p>		<p>PLACE OF BURIAL <i>Greenwood Cemetery, Baltimore, Md.</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

1934

1

RECEIVED
MAY 10 1934
BALTIMORE, MD.

5325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY SPARKS Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stirling Middle Albert Last Mays		4. DATE OF DEATH Month 5 Day 31 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-16-1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Tool mfg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Mays		14. MOTHER'S MAIDEN NAME Elizabeth Stirling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-5349	
17. INFORMANT Mrs. Baker C. Johnson		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio vascular disease with 443X DUE TO left side hemiplegia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 58 , to May 31 , 19 59 , that I last saw the deceased alive on May 29 , 19 59 , and that death occurred at 6.20a A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE A.M. France M.D.			
PHYSICIAN'S NAME (Type) A.M. Brance Parkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-3-59	22c. NAME OF CEMETERY OR CREMATORY Foster's	22d. LOCATION (City, town, or county) (State) Monkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JUN 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Brooks Funeral Service, Towson, Md.

6-7-50 Boston's

Boston, Md.

A. J. Vance

Boston, Md.

1950 - May 31

1950 - May 31

1950 - May 31

1950 - May 31

1950 - May 31

1950 - May 31

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1950 - May 31

1950 - May 31

1950 - May 31

1950 - May 31

1950 - May 31

1950 - May 31

Reg. Dist. No.

05305

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 42 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES		Middle B.	
Last McBEE		4. DATE OF DEATH Month May	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1880	
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months 21	
11. IF UNDER 24 HRS. Days 19		Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Company	
11. BIRTHPLACE (State or foreign country) Morgan Co., W. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis McBee		14. MOTHER'S MAIDEN NAME Annie Spohr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) LOBULAR PNEUMONIA DUE TO (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1959 , to May 21, 1959 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 5/22/59			
ACTUAL SIGNATURE John W. Crawford		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR MAY 27 '59	
ADDRESS 6009 Harford Rd., Balto 14		24b. REGISTRAR'S SIGNATURE Arthur L. Rouse	

VS A15 (4)
15M 10/57

VS A1S (4)
15M 10/57

CERTIFICATE OF DEATH

12345

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1920	
Place of Birth		Race		Color		Religion	
New York City		White		White		Roman Catholic	
Marital Status		Cause of Death		Manner of Death		Place of Death	
Married		Heart Disease		Natural		Home	
Occupation		Education		Signature of Physician		Signature of Registrar	
Teacher		High School		[Signature]		[Signature]	
Date of Death		Time of Death		Hospital		City	
Jan 15, 1965		10:30 AM		St. Mary's		Baltimore	
Physician's Name		Physician's Address		Physician's Phone		Physician's License No.	
Dr. J. Smith		123 Main St.		555-1234		12345	
Registrar's Name		Registrar's Address		Registrar's Phone		Registrar's License No.	
Mr. A. Jones		456 Oak St.		555-5678		67890	

CERTIFICATE OF DEATH

05306

Reg. Dist. No.

5327

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Haddington Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle P. Last McGINN				4. DATE OF DEATH Month May Day 5 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1894		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 6 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist			10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert McGinn				14. MOTHER'S MAIDEN NAME Julia Hayden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-26-1823		17. INFORMANT Mrs. Ed. J. Coniff-25 Haddington Rd.		Address Lutherville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2 , 19 59 , to May 5 , 19 59 that I last saw the deceased alive on May 2 , 19 59 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Gilmore M.D.				ADDRESS (Street, city or town, state) Lutherville, Md			
DATE SIGNED 5/7/59							
PHYSICIAN'S NAME (Type) GEORGE T. GILMORE				LUTHERVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson				24a. REC'D BY REGISTRAR DATE MAY 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5328 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1901 Clifden Rd.				1 d. STREET ADDRESS 1901 Clifden Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas McGronan				4. DATE OF DEATH Month May Day 27 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John J. McGronan				14. MOTHER'S MAIDEN NAME Rose O'Hanlon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Mrs. W.T. McGronan 1901 Clifden Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Cardio Vascular disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 26 years						INTERVAL BETWEEN ONSET AND DEATH 26 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935 , 19 5-27- , 19 59 , that I last saw the deceased alive on 5-27- , 19 59 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 715 N. Charles St. Balto. Md. DATE SIGNED 5-29-59 ACTUAL SIGNATURE S. Demanco Jr. M.D. 715 N. Charles St. Balto. Md. PHYSICIAN'S NAME (Type) S. Demanco Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-30-59		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville Md.				24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

05307

CERTIFICATE OF DEATH

1922

1

STATE OF NEW YORK

DEPARTMENT OF HEALTH

Blank form area for death certificate details, including fields for name, age, sex, date of death, and cause of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5329

CERTIFICATE OF DEATH

Reg. Dist. No. 05308

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> <u>Co</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3001.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines, 16 Fusting AVE</u>		d. STREET ADDRESS <u>620 W. HAMBURG ST</u>	
3. NAME OF DECEASED (Type or print) <u>HENRIETTA</u> First <u>Elizabeth</u> Middle <u>Messz.</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK H.T. Messz</u>		14. MOTHER'S MARDEN NAME <u>ANNIE E. Stuben</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Charles Winkschmidt</u>		Address <u>38 Overbrook Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1, 1956</u> to <u>5/1, 1959</u> , that I last saw the deceased alive on <u>5/1, 1959</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Maurice Feldman</u>		M.D. <u>25 Read St. Baltimore</u> DATE SIGNED <u>5/2/59</u>	
PHYSICIAN'S NAME (Type) <u>MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lowden Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCall's Funeral Homes</u>		ADDRESS <u>BALTO MD.</u>	
24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5330

CERTIFICATE OF DEATH

05310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yrl4mth25dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights, Maryland 1634-2		d. STREET ADDRESS 6222 Kingston Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle King (Last) (Miller) Migliccio		4. DATE OF DEATH Month May Day 20 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879?
9. AGE (In years last birthday) 79? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Ireland ✓	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 11 , 19 59 , to May 20 , 19 59 , that I last saw the deceased alive on May 20 , 19 59 , and that death occurred at 2:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-20-59			
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		ADDRESS Mt. Rainier	
24a. REC'D BY REGISTRAR May 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH
Baltimore, Md.
JAN 10 1920
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 5, 1920		10:30 AM		Home	
Physician		Burial		Interment	
Dr. J. Smith		St. Mary's Church		Cemetery	
Signature of Physician		Signature of Burial Officer		Signature of Interment Officer	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05309

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 18 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1730 Winans Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lelia Elizabeth Miller		4. DATE OF DEATH Month Day Year May 22, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1906
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles C. Albiker		14. MOTHER'S MAIDEN NAME Mary A. Wortman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. W. Norris Miller		Address 1730 Winans Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary carcinoma of the breast- 1955 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 21, 1955 to May 22, 1959 , that I last saw the deceased alive on May 22, 1959 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George A. Knipp, M. D. 4116 Edmondson Ave., Balto., Md. 5-22-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Knipp, M. D.		24a. REC'D BY REGISTRAR May 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3a, Film G-242 5/18/59, one.

Reg. Dist. No. 05311

1. PLACE OF DEATH a. COUNTY Baltimore 5331 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Conn. b. COUNTY Lynchfield		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winsted 45X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			d. STREET ADDRESS 120 Holibird Ave.		
3. NAME OF DECEASED (Type or print) Bertram Berton S. Mitchell			4. DATE OF DEATH Month May Day 12 Year 19 59		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/09		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Elec. Houseware		11. BIRTHPLACE (State or foreign country) New York City	
12. CITIZEN OF WHAT COUNTRY? America			13. FATHER'S NAME Samuel Schwartz		
14. MOTHER'S MAIDEN NAME ? Doctors			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Nat. Guard		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr. Irving Singer		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash		20c. TIME OF INJURY Month, Day, Year Hour 5:15 p. m. 5/12 19 59			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/12/59	
EXAMINER'S NAME (Type) M. B. Davis		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORY Winsted Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Hickner & Sons		ADDRESS Balto 17		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05312

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Brooklyn		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 69x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			d. STREET ADDRESS 91 New Jersey Avenue		
3. NAME OF DECEASED (Type or print) First Harold Middle Mitnick Last Mitnick			4. DATE OF DEATH Month May Day 12 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1923		9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY Federal Gov't		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME David Mitnick			14. MOTHER'S MAIDEN NAME Ray Fischer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Boulevard Funeral Chapel Brooklyn, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash			
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 19 59	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/12/59	
EXAMINER'S NAME (Type) M. B. Davis		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF May 15	22c. NAME OF CEMETERY Monte Fiore		22d. LOCATION (City, town, or county) (State) Spring Field Long Island, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Sal Levinson & Bros. Balt. Md.		24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02313

CERTIFICATE OF DEATH

02313

[Faint, illegible text, likely bleed-through from the reverse side of the document]

5334

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Catonsville, Baltimore Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville.				c. LENGTH OF STAY IN 1b 52 Catonsville.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 50 Dungarrie Rd.				d. STREET ADDRESS 50 Dungarrie Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HORACE B NEFF				4. DATE OF DEATH Month Day Year May 1 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1909		9. AGE (In years lost birthday) yrs. 50	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Traffic		11. BIRTHPLACE (State or foreign country) Clifton, Arizona		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James B. Neff				14. MOTHER'S MAIDEN NAME Coffee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no 547-03-5767		INFORMANT Mrs. Margaret Neff, 50 Dungarrie Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 5 min.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 2, 1959 to May 1, 1959 that I last saw the deceased alive on April 29, 1959, and that death occurred at 2:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John F. Schaefer M.D. 401 Random Road 5/3/59 John F. Schaefer Balto. 29 Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-1959		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Frederick Ave. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE THOMAS J. KENNY, INC. 1600 HOLLINS ST. BALTO. MD.				24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b 54 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 865 Back River Neck Road		d. STREET ADDRESS 865 Back River Neck Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BESSIE ELIZABETH O'CONNOR		4. DATE OF DEATH May 15, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Home	
13. FATHER'S NAME ? Beall		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alice E. O'Connor		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack C. Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack C. Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-15-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/59	
22c. NAME OF CEMETERY OR CREMATORY Lorriane Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James C. Bruzdinski		24a. REC'D BY REGISTRAR DATE MAY 18 '59	
ADDRESS 1407 Eastern Ave.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

STATE OF MARYLAND
HEALTH DEPT.

1

1

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH, OFFICE OF THE COMMISSIONER, CERTIFICATE OF MENTAL EXAMINATION OF

5385

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF MENTAL EXAMINATION

NAME OF PATIENT

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

ADDRESS

DATE OF BIRTH

SEX

AGE

HEIGHT

WEIGHT

DATE OF ADMISSION

IF CASE OF MENTAL DISEASE, STATE THE NATURE OF THE DISEASE

DATE OF ONSET OF DISEASE

DATE OF LAST EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

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DATE OF PRESENT EXAMINATION

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DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

DATE OF PRESENT EXAMINATION

FOR STATE
HEALTH DEPT.

5336

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05316

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>County</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6614 Kilmarnock Lane</u>			d. STREET ADDRESS <u>1653 Orpington Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Clare</u> Middle <u>O'Keefe</u> Last			4. DATE OF DEATH <u>May</u> Month <u>24</u> Day <u>1957</u> Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7 1897</u>		9. AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City School</u>		11. BIRTHPLACE (State or foreign country) <u>Balto</u>	
12. CITIZEN OF WHAT COUNTRY? <u>usa</u>			13. FATHER'S NAME <u>William O'Keefe</u>		
14. MOTHER'S MAIDEN NAME <u>Permy</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>220-22-1200</u>			17. INFORMANT <u>Edna O'Keefe</u> Address <u>653 Orpington Rd</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. J. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 25, 59</u>	
EXAMINER'S NAME (Type) <u>GEO. S. H. KIEFFER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>	
22d. LOCATION (City, town, or county) <u>Balto</u>		(State) <u>md</u>		24a. REC'D BY REGISTRAR <u>MAY 27 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Teufel</u>		ADDRESS <u>5311 Edmondson Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5337

CERTIFICATE OF DEATH

05317

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b <u>3Y01-4</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Professional House</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3809 Barington Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Solomon</u> Middle <u>Oletsky</u> Last <u>Oletsky</u>		4. DATE OF DEATH <u>May 15</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1903</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Proprietor</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Oletsky</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Ostrowsky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pauline Oletsky - 3809 Barington Rd</u>	
17. INFORMANT <u>Pauline Oletsky</u>		Address <u>3809 Barington Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke (C. V. A.)</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO <u>10 years</u> (c) <u>Diabetes mellitus</u> DUE TO <u>4 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/22</u> , 19 <u>52</u> , to <u>5/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>59</u> , and that death occurred at <u>6:00 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>2320 Ertaw Pl</u>			
ACTUAL SIGNATURE <u>Dr. I. S. ZINBERG</u>		M.D. <u>Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>DR. I. S. ZINBERG</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Towers B. Oakland</u>	22d. LOCATION (City, town, or county) (State) <u>Medale, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Herman</u>		24a. REC'D BY REGISTRAR <u>1124-26 W. North St</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 10 1918		BALTIMORE	
HUSBAND		WIFE	
JAMES C. [illegible]		[illegible]	
AGE		AGE	
45		35	
SEX		SEX	
MALE		FEMALE	
RACE		RACE	
WHITE		WHITE	
EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		OCCUPATION	
[illegible]		[illegible]	
CAUSE OF DEATH		CAUSE OF DEATH	
[illegible]		[illegible]	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
DATE OF BURIAL		DATE OF BURIAL	
JAN 12 1918		JAN 12 1918	
PLACE OF BURIAL		PLACE OF BURIAL	
[illegible]		[illegible]	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
[illegible]		[illegible]	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[illegible]		[illegible]	
DATE OF CERTIFICATE		DATE OF CERTIFICATE	
JAN 10 1918		JAN 10 1918	
PLACE OF CERTIFICATE		PLACE OF CERTIFICATE	
BALTIMORE		BALTIMORE	

THIS IS A SUMMARY OF THE INFORMATION CONTAINED IN THE ORIGINAL RECORD OF THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, FOR THE YEAR 1918.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5338 CERTIFICATE OF DEATH

05318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5005 Hazelwood Ave.</u>		d. STREET ADDRESS <u>5005 Hazelwood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S.</u> Last <u>Oliver</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upholstering</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John S. Oliver</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Caroline I. Oliver</u>		Address <u>5005 Hazelwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis; Multiple recurrent thromboses</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>52</u> , to <u>31 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>25 May</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Brennan</u> M.D.		ADDRESS (Street, city or town, state) <u>5217 Harford Road Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>Thomas Brennan</u>		DATE SIGNED <u>2 June 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

5038 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES E. BROWN		45		M		W		1900		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
MARRIED		1925		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		BUSINESS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
MANAGER		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		HEART		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
CORONARY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MANNER OF DEATH		NATURAL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
NATURAL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		1945		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
1945		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
PLACE OF DEATH		HOME		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HOME		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF REPORT		1945		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
1945		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
REPORTED BY		DOCTOR		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
DOCTOR		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE		JAMES E. BROWN		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
JAMES E. BROWN		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	



James E. Brown
 JAMES E. BROWN
 BALTIMORE, MARYLAND

FOR STATE
HEALTH DEPT.

5339

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grosse Pointe 59X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 11760 White Hall			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C Last PADDACK				4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/1/06	
9. AGE (In years last birthday) 52 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot				10b. KIND OF BUSINESS OR INDUSTRY Airplane		11. BIRTHPLACE (State or foreign country) Penn.	
13. FATHER'S NAME Edward E. Paddock				14. MOTHER'S MAIDEN NAME Jessie Richard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes unknown		17. INFORMANT Address Charles Verheyden Funeral Home - Detroit, Mich.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 861X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Charles O'Donnell		DATE SIGNED 5/12/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/59		22c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery		22d. LOCATION (City, town, or county) Oakland County Mich.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran 3000 E. Balto. St. Balto. Md.				24a. REC'D BY REGISTRAR MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Klaus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEPARTMENT

2382

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

1

Male

White

5/1/08

5/1/08

Albino

Gen.

John A. Ryan

John A. Ryan

1

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

John A. Ryan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5172

CERTIFICATE OF DEATH

Reg. Dist. No.

05320

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Baltimore 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION * 2472 Keyway		d. STREET ADDRESS 2472 Keyway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Victoria Panceszyn		4. DATE OF DEATH May 12 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME ? Krysko		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mary Plucinski		Address 2472 Keyway Balto 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON'S Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1954 to May 12 1959 , that I last saw the deceased alive on May 5 1959 , and that death occurred at 505 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6800 MORNINTON RD ACTUAL SIGNATURE M B Davis M.D. Dundalk. 22 Md 5/14/59 PHYSICIAN'S NAME (Type) M B DAVIS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/1959	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Helmer & Sons Inc. 401 S. Chester St.		24a. REC'D BY REGISTRAR DATE MAY 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

CERTIFICATE OF DEATH

1173

00350

PLACE OF BIRTH Baltimore		PLACE OF DEATH Baltimore	
DATE OF BIRTH 11/15/1891		DATE OF DEATH 11/15/1951	
SEX Male		SEX Male	
RACE White		RACE White	
OCCUPATION Unknown		OCCUPATION Unknown	
MARITAL STATUS Single		MARITAL STATUS Single	
CAUSE OF DEATH Unknown		CAUSE OF DEATH Unknown	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF DECEASED [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF CLERK [Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1903, AS AMENDED BY THE ACT OF 1926, AND THE ACT OF 1934, AND THE ACT OF 1948, AND THE ACT OF 1950, AND THE ACT OF 1952, AND THE ACT OF 1954, AND THE ACT OF 1956, AND THE ACT OF 1958, AND THE ACT OF 1960, AND THE ACT OF 1962, AND THE ACT OF 1964, AND THE ACT OF 1966, AND THE ACT OF 1968, AND THE ACT OF 1970, AND THE ACT OF 1972, AND THE ACT OF 1974, AND THE ACT OF 1976, AND THE ACT OF 1978, AND THE ACT OF 1980, AND THE ACT OF 1982, AND THE ACT OF 1984, AND THE ACT OF 1986, AND THE ACT OF 1988, AND THE ACT OF 1990, AND THE ACT OF 1992, AND THE ACT OF 1994, AND THE ACT OF 1996, AND THE ACT OF 1998, AND THE ACT OF 2000, AND THE ACT OF 2002, AND THE ACT OF 2004, AND THE ACT OF 2006, AND THE ACT OF 2008, AND THE ACT OF 2010, AND THE ACT OF 2012, AND THE ACT OF 2014, AND THE ACT OF 2016, AND THE ACT OF 2018, AND THE ACT OF 2020.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5340

CERTIFICATE OF DEATH

Reg. Dist. 05321

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Roxwood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHLEEN</u> Middle <u>LYLE</u> Last <u>PATTERSON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1952</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane McKensie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Chart - Roxwood Training School</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, bilateral</u> <u>002 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the <u>under-</u> lying cause last. (c) <u>tuberculosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Undiagnosed disease of the nervous system & seizures</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u> <u>at least 1 year</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 31</u> , 19 <u>58</u> , to <u>MAY 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 20</u> , 19 <u>59</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Olive Reid Harris MD</u>		DATE SIGNED <u>May 20 1959</u>	
PHYSICIAN'S NAME (Type) <u>Olive Reid Harris, MD</u>		<u>OWINGS MILLS, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edlington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft Meyer Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald F. H. 816-H-STAKE Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ORIGINAL

W 2363

CERTIFICATE OF DEATH

W 2363

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Discernible fragments include:]

... of ...
... born ...
... died ...
... cause of death ...
... signed ...
... date ...
... place ...
... registrar ...
... official ...
... seal ...

THIS IS A PERMANENT RECORD

PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK. DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. IS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER I

5341

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05322

1. NAME OF DECEASED
(Type or Print)

Texie Pennington

2. DATE OF DEATH

May 21, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address
HOSPITAL OR for location)
INSTITUTION 30 South Hawthorne Rd
Baltimore 20 (Middle River)4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE before admission)

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give
54 Middle River, Baltimore 20 township)

D. STREET ADDRESS (If rural, give location)

30 South Hawthorne Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Nov. 29, 1875

9. AGE (In years
last birthday)

83

If Under 1 Year

Months

Days

If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind
of work done during most of working life, even if retired)
Housewife10B. KIND OF BUSINESS OR
INDUSTRY11. BIRTHPLACE (State or foreign country)
Summers Co., W.Va.12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James Meadows

15. Was Deceased Ever in U.S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Blanche Maher, 30 S. Hawthorne Rd

18.

443X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hippert's C. V. Disease

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE
TO THE ABOVE CAUSE (A) STATING THE UNDER-
LYING CONDITION LAST.

(B)

DUE TO

15 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OF PART II
21D. TIME (Month) (Day) (Year) Hour)
OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1955 to May 21, 1959, that (I) (we) last saw the deceased alive on May 17, 1959, and that in (my) (our) opinion death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

1825 Eastern Bell

5/22/59

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

REMOVAL

5-22-59

Forrest Hill Cemetery

Summers Co., West Virginia

DATE RECEIVED BY
REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAY 22 '59

Arthur S. Hume

Wm. Cook, Inc., 1217 St. Paul Street

I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland.
 Given under my hand and the seal of the State of Maryland, this 1st day of January, 1901.
 JOHN W. HARRIS, Secretary of State.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. COLOR 8. RELIGION 9. MARRIED 10. DATE OF MARRIAGE 11. NAME OF SPOUSE 12. NAME OF FATHER 13. NAME OF MOTHER 14. DATE OF DEATH 15. PLACE OF DEATH 16. CAUSE OF DEATH 17. TIME OF DEATH 18. SEX OF DECEASED 19. AGE OF DECEASED 20. DATE OF BIRTH 21. PLACE OF BIRTH 22. OCCUPATION 23. COLOR 24. RELIGION 25. MARRIED 26. DATE OF MARRIAGE 27. NAME OF SPOUSE 28. NAME OF FATHER 29. NAME OF MOTHER 30. DATE OF DEATH 31. PLACE OF DEATH 32. CAUSE OF DEATH 33. TIME OF DEATH 34. SEX OF DECEASED 35. AGE OF DECEASED 36. DATE OF BIRTH 37. PLACE OF BIRTH 38. OCCUPATION 39. COLOR 40. RELIGION 41. MARRIED 42. DATE OF MARRIAGE 43. NAME OF SPOUSE 44. NAME OF FATHER 45. NAME OF MOTHER 46. DATE OF DEATH 47. PLACE OF DEATH 48. CAUSE OF DEATH 49. TIME OF DEATH 50. SEX OF DECEASED 51. AGE OF DECEASED 52. DATE OF BIRTH 53. PLACE OF BIRTH 54. OCCUPATION 55. COLOR 56. RELIGION 57. MARRIED 58. DATE OF MARRIAGE 59. NAME OF SPOUSE 60. NAME OF FATHER 61. NAME OF MOTHER 62. DATE OF DEATH 63. PLACE OF DEATH 64. CAUSE OF DEATH 65. TIME OF DEATH 66. SEX OF DECEASED 67. AGE OF DECEASED 68. DATE OF BIRTH 69. PLACE OF BIRTH 70. OCCUPATION 71. COLOR 72. RELIGION 73. MARRIED 74. DATE OF MARRIAGE 75. NAME OF SPOUSE 76. NAME OF FATHER 77. NAME OF MOTHER 78. DATE OF DEATH 79. PLACE OF DEATH 80. CAUSE OF DEATH 81. TIME OF DEATH 82. SEX OF DECEASED 83. AGE OF DECEASED 84. DATE OF BIRTH 85. PLACE OF BIRTH 86. OCCUPATION 87. COLOR 88. RELIGION 89. MARRIED 90. DATE OF MARRIAGE 91. NAME OF SPOUSE 92. NAME OF FATHER 93. NAME OF MOTHER 94. DATE OF DEATH 95. PLACE OF DEATH 96. CAUSE OF DEATH 97. TIME OF DEATH 98. SEX OF DECEASED 99. AGE OF DECEASED 100. DATE OF BIRTH 101. PLACE OF BIRTH 102. OCCUPATION 103. COLOR 104. RELIGION 105. MARRIED 106. DATE OF MARRIAGE 107. NAME OF SPOUSE 108. NAME OF FATHER 109. NAME OF MOTHER 110. DATE OF DEATH 111. PLACE OF DEATH 112. CAUSE OF DEATH 113. TIME OF DEATH 114. SEX OF DECEASED 115. AGE OF DECEASED 116. DATE OF BIRTH 117. PLACE OF BIRTH 118. OCCUPATION 119. COLOR 120. RELIGION 121. MARRIED 122. DATE OF MARRIAGE 123. NAME OF SPOUSE 124. NAME OF FATHER 125. NAME OF MOTHER 126. DATE OF DEATH 127. PLACE OF DEATH 128. CAUSE OF DEATH 129. TIME OF DEATH 130. SEX OF DECEASED 131. AGE OF DECEASED 132. DATE OF BIRTH 133. PLACE OF BIRTH 134. OCCUPATION 135. COLOR 136. RELIGION 137. MARRIED 138. DATE OF MARRIAGE 139. NAME OF SPOUSE 140. NAME OF FATHER 141. NAME OF MOTHER 142. DATE OF DEATH 143. PLACE OF DEATH 144. CAUSE OF DEATH 145. TIME OF DEATH 146. SEX OF DECEASED 147. AGE OF DECEASED 148. DATE OF BIRTH 149. PLACE OF BIRTH 150. OCCUPATION 151. COLOR 152. RELIGION 153. MARRIED 154. DATE OF MARRIAGE 155. NAME OF SPOUSE 156. NAME OF FATHER 157. NAME OF MOTHER 158. DATE OF DEATH 159. PLACE OF DEATH 160. CAUSE OF DEATH 161. TIME OF DEATH 162. SEX OF DECEASED 163. AGE OF DECEASED 164. DATE OF BIRTH 165. PLACE OF BIRTH 166. OCCUPATION 167. COLOR 168. RELIGION 169. MARRIED 170. DATE OF MARRIAGE 171. NAME OF SPOUSE 172. NAME OF FATHER 173. NAME OF MOTHER 174. DATE OF DEATH 175. PLACE OF DEATH 176. CAUSE OF DEATH 177. TIME OF DEATH 178. SEX OF DECEASED 179. AGE OF DECEASED 180. DATE OF BIRTH 181. PLACE OF BIRTH 182. OCCUPATION 183. COLOR 184. RELIGION 185. MARRIED 186. DATE OF MARRIAGE 187. NAME OF SPOUSE 188. NAME OF FATHER 189. NAME OF MOTHER 190. DATE OF DEATH 191. PLACE OF DEATH 192. CAUSE OF DEATH 193. TIME OF DEATH 194. SEX OF DECEASED 195. AGE OF DECEASED 196. DATE OF BIRTH 197. PLACE OF BIRTH 198. OCCUPATION 199. COLOR 200. RELIGION 201. MARRIED 202. DATE OF MARRIAGE 203. NAME OF SPOUSE 204. NAME OF FATHER 205. NAME OF MOTHER 206. DATE OF DEATH 207. PLACE OF DEATH 208. CAUSE OF DEATH 209. TIME OF DEATH 210. SEX OF DECEASED 211. AGE OF DECEASED 212. DATE OF BIRTH 213. PLACE OF BIRTH 214. OCCUPATION 215. COLOR 216. RELIGION 217. MARRIED 218. DATE OF MARRIAGE 219. NAME OF SPOUSE 220. NAME OF FATHER 221. NAME OF MOTHER 222. DATE OF DEATH 223. PLACE OF DEATH 224. CAUSE OF DEATH 225. TIME OF DEATH 226. SEX OF DECEASED 227. AGE OF DECEASED 228. DATE OF BIRTH 229. PLACE OF BIRTH 230. OCCUPATION 231. COLOR 232. RELIGION 233. MARRIED 234. DATE OF MARRIAGE 235. NAME OF SPOUSE 236. NAME OF FATHER 237. NAME OF MOTHER 238. DATE OF DEATH 239. PLACE OF DEATH 240. CAUSE OF DEATH 241. TIME OF DEATH 242. SEX OF DECEASED 243. AGE OF DECEASED 244. DATE OF BIRTH 245. PLACE OF BIRTH 246. OCCUPATION 247. COLOR 248. RELIGION 249. MARRIED 250. DATE OF MARRIAGE 251. NAME OF SPOUSE 252. NAME OF FATHER 253. NAME OF MOTHER 254. DATE OF DEATH 255. PLACE OF DEATH 256. CAUSE OF DEATH 257. TIME OF DEATH 258. SEX OF DECEASED 259. AGE OF DECEASED 260. DATE OF BIRTH 261. PLACE OF BIRTH 262. OCCUPATION 263. COLOR 264. RELIGION 265. MARRIED 266. DATE OF MARRIAGE 267. NAME OF SPOUSE 268. NAME OF FATHER 269. NAME OF MOTHER 270. DATE OF DEATH 271. PLACE OF DEATH 272. CAUSE OF DEATH 273. TIME OF DEATH 274. SEX OF DECEASED 275. AGE OF DECEASED 276. DATE OF BIRTH 277. PLACE OF BIRTH 278. OCCUPATION 279. COLOR 280. RELIGION 281. MARRIED 282. DATE OF MARRIAGE 283. NAME OF SPOUSE 284. NAME OF FATHER 285. NAME OF MOTHER 286. DATE OF DEATH 287. PLACE OF DEATH 288. CAUSE OF DEATH 289. TIME OF DEATH 290. SEX OF DECEASED 291. AGE OF DECEASED 292. DATE OF BIRTH 293. PLACE OF BIRTH 294. OCCUPATION 295. COLOR 296. RELIGION 297. MARRIED 298. DATE OF MARRIAGE 299. NAME OF SPOUSE 300. NAME OF FATHER 301. NAME OF MOTHER 302. DATE OF DEATH 303. PLACE OF DEATH 304. CAUSE OF DEATH 305. TIME OF DEATH 306. SEX OF DECEASED 307. AGE OF DECEASED 308. DATE OF BIRTH 309. PLACE OF BIRTH 310. OCCUPATION 311. COLOR 312. RELIGION 313. MARRIED 314. DATE OF MARRIAGE 315. NAME OF SPOUSE 316. NAME OF FATHER 317. NAME OF MOTHER 318. DATE OF DEATH 319. PLACE OF DEATH 320. CAUSE OF DEATH 321. TIME OF DEATH 322. SEX OF DECEASED 323. AGE OF DECEASED 324. DATE OF BIRTH 325. PLACE OF BIRTH 326. OCCUPATION 327. COLOR 328. RELIGION 329. MARRIED 330. DATE OF MARRIAGE 331. NAME OF SPOUSE 332. NAME OF FATHER 333. NAME OF MOTHER 334. DATE OF DEATH 335. PLACE OF DEATH 336. CAUSE OF DEATH 337. TIME OF DEATH 338. SEX OF DECEASED 339. AGE OF DECEASED 340. DATE OF BIRTH 341. PLACE OF BIRTH 342. OCCUPATION 343. COLOR 344. RELIGION 345. MARRIED 346. DATE OF MARRIAGE 347. NAME OF SPOUSE 348. NAME OF FATHER 349. NAME OF MOTHER 350. DATE OF DEATH 351. PLACE OF DEATH 352. CAUSE OF DEATH 353. TIME OF DEATH 354. SEX OF DECEASED 355. AGE OF DECEASED 356. DATE OF BIRTH 357. PLACE OF BIRTH 358. OCCUPATION 359. COLOR 360. RELIGION 361. MARRIED 362. DATE OF MARRIAGE 363. NAME OF SPOUSE 364. NAME OF FATHER 365. NAME OF MOTHER 366. DATE OF DEATH 367. PLACE OF DEATH 368. CAUSE OF DEATH 369. TIME OF DEATH 370. SEX OF DECEASED 371. AGE OF DECEASED 372. DATE OF BIRTH 373. PLACE OF BIRTH 374. OCCUPATION 375. COLOR 376. RELIGION 377. MARRIED 378. DATE OF MARRIAGE 379. NAME OF SPOUSE 380. NAME OF FATHER 381. NAME OF MOTHER 382. DATE OF DEATH 383. PLACE OF DEATH 384. CAUSE OF DEATH 385. TIME OF DEATH 386. SEX OF DECEASED 387. AGE OF DECEASED 388. DATE OF BIRTH 389. PLACE OF BIRTH 390. OCCUPATION 391. COLOR 392. RELIGION 393. MARRIED 394. DATE OF MARRIAGE 395. NAME OF SPOUSE 396. NAME OF FATHER 397. NAME OF MOTHER 398. DATE OF DEATH 399. PLACE OF DEATH 400. CAUSE OF DEATH 401. TIME OF DEATH 402. SEX OF DECEASED 403. AGE OF DECEASED 404. DATE OF BIRTH 405. PLACE OF BIRTH 406. OCCUPATION 407. COLOR 408. RELIGION 409. MARRIED 410. DATE OF MARRIAGE 411. NAME OF SPOUSE 412. NAME OF FATHER 413. NAME OF MOTHER 414. DATE OF DEATH 415. PLACE OF DEATH 416. CAUSE OF DEATH 417. TIME OF DEATH 418. SEX OF DECEASED 419. AGE OF DECEASED 420. DATE OF BIRTH 421. PLACE OF BIRTH 422. OCCUPATION 423. COLOR 424. RELIGION 425. MARRIED 426. DATE OF MARRIAGE 427. NAME OF SPOUSE 428. NAME OF FATHER 429. NAME OF MOTHER 430. DATE OF DEATH 431. PLACE OF DEATH 432. CAUSE OF DEATH 433. TIME OF DEATH 434. SEX OF DECEASED 435. AGE OF DECEASED 436. DATE OF BIRTH 437. PLACE OF BIRTH 438. OCCUPATION 439. COLOR 440. RELIGION 441. MARRIED 442. DATE OF MARRIAGE 443. NAME OF SPOUSE 444. NAME OF FATHER 445. NAME OF MOTHER 446. DATE OF DEATH 447. PLACE OF DEATH 448. CAUSE OF DEATH 449. TIME OF DEATH 450. SEX OF DECEASED 451. AGE OF DECEASED 452. DATE OF BIRTH 453. PLACE OF BIRTH 454. OCCUPATION 455. COLOR 456. RELIGION 457. MARRIED 458. DATE OF MARRIAGE 459. NAME OF SPOUSE 460. NAME OF FATHER 461. NAME OF MOTHER 462. DATE OF DEATH 463. PLACE OF DEATH 464. CAUSE OF DEATH 465. TIME OF DEATH 466. SEX OF DECEASED 467. AGE OF DECEASED 468. DATE OF BIRTH 469. PLACE OF BIRTH 470. OCCUPATION 471. COLOR 472. RELIGION 473. MARRIED 474. DATE OF MARRIAGE 475. NAME OF SPOUSE 476. NAME OF FATHER 477. NAME OF MOTHER 478. DATE OF DEATH 479. PLACE OF DEATH 480. CAUSE OF DEATH 481. TIME OF DEATH 482. SEX OF DECEASED 483. AGE OF DECEASED 484. DATE OF BIRTH 485. PLACE OF BIRTH 486. OCCUPATION 487. COLOR 488. RELIGION 489. MARRIED 490. DATE OF MARRIAGE 491. NAME OF SPOUSE 492. NAME OF FATHER 493. NAME OF MOTHER 494. DATE OF DEATH 495. PLACE OF DEATH 496. CAUSE OF DEATH 497. TIME OF DEATH 498. SEX OF DECEASED 499. AGE OF DECEASED 500. DATE OF BIRTH 501. PLACE OF BIRTH 502. OCCUPATION 503. COLOR 504. RELIGION 505. MARRIED 506. DATE OF MARRIAGE 507. NAME OF SPOUSE 508. NAME OF FATHER 509. NAME OF MOTHER 510. DATE OF DEATH 511. PLACE OF DEATH 512. CAUSE OF DEATH 513. TIME OF DEATH 514. SEX OF DECEASED 515. AGE OF DECEASED 516. DATE OF BIRTH 517. PLACE OF BIRTH 518. OCCUPATION 519. COLOR 520. RELIGION 521. MARRIED 522. DATE OF MARRIAGE 523. NAME OF SPOUSE 524. NAME OF FATHER 525. NAME OF MOTHER 526. DATE OF DEATH 527. PLACE OF DEATH 528. CAUSE OF DEATH 529. TIME OF DEATH 530. SEX OF DECEASED 531. AGE OF DECEASED 532. DATE OF BIRTH 533. PLACE OF BIRTH 534. OCCUPATION 535. COLOR 536. RELIGION 537. MARRIED 538. DATE OF MARRIAGE 539. NAME OF SPOUSE 540. NAME OF FATHER 541. NAME OF MOTHER 542. DATE OF DEATH 543. PLACE OF DEATH 544. CAUSE OF DEATH 545. TIME OF DEATH 546. SEX OF DECEASED 547. AGE OF DECEASED 548. DATE OF BIRTH 549. PLACE OF BIRTH 550. OCCUPATION 551. COLOR 552. RELIGION 553. MARRIED 554. DATE OF MARRIAGE 555. NAME OF SPOUSE 556. NAME OF FATHER 557. NAME OF MOTHER 558. DATE OF DEATH 559. PLACE OF DEATH 560. CAUSE OF DEATH 561. TIME OF DEATH 562. SEX OF DECEASED 563. AGE OF DECEASED 564. DATE OF BIRTH 565. PLACE OF BIRTH 566. OCCUPATION 567. COLOR 568. RELIGION 569. MARRIED 570. DATE OF MARRIAGE 571. NAME OF SPOUSE 572. NAME OF FATHER 573. NAME OF MOTHER 574. DATE OF DEATH 575. PLACE OF DEATH 576. CAUSE OF DEATH 577. TIME OF DEATH 578. SEX OF DECEASED 579. AGE OF DECEASED 580. DATE OF BIRTH 581. PLACE OF BIRTH 582. OCCUPATION 583. COLOR 584. RELIGION 585. MARRIED 586. DATE OF MARRIAGE 587. NAME OF SPOUSE 588. NAME OF FATHER 589. NAME OF MOTHER 590. DATE OF DEATH 591. PLACE OF DEATH 592. CAUSE OF DEATH 593. TIME OF DEATH 594. SEX OF DECEASED 595. AGE OF DECEASED 596. DATE OF BIRTH 597. PLACE OF BIRTH 598. OCCUPATION 599. COLOR 600. RELIGION 601. MARRIED 602. DATE OF MARRIAGE 603. NAME OF SPOUSE 604. NAME OF FATHER 605. NAME OF MOTHER 606. DATE OF DEATH 607. PLACE OF DEATH 608. CAUSE OF DEATH 609. TIME OF DEATH 610. SEX OF DECEASED 611. AGE OF DECEASED 612. DATE OF BIRTH 613. PLACE OF BIRTH 614. OCCUPATION 615. COLOR 616. RELIGION 617. MARRIED 618. DATE OF MARRIAGE 619. NAME OF SPOUSE 620. NAME OF FATHER 621. NAME OF MOTHER 622. DATE OF DEATH 623. PLACE OF DEATH 624. CAUSE OF DEATH 625. TIME OF DEATH 626. SEX OF DECEASED 627. AGE OF DECEASED 628. DATE OF BIRTH 629. PLACE OF BIRTH 630. OCCUPATION 631. COLOR 632. RELIGION 633. MARRIED 634. DATE OF MARRIAGE 635. NAME OF SPOUSE 636. NAME OF FATHER 637. NAME OF MOTHER 638. DATE OF DEATH 639. PLACE OF DEATH 640. CAUSE OF DEATH 641. TIME OF DEATH 642. SEX OF DECEASED 643. AGE OF DECEASED 644. DATE OF BIRTH 645. PLACE OF BIRTH 646. OCCUPATION 647. COLOR 648. RELIGION 649. MARRIED 650. DATE OF MARRIAGE 651. NAME OF SPOUSE 652. NAME OF FATHER 653. NAME OF MOTHER 654. DATE OF DEATH 655. PLACE OF DEATH 656. CAUSE OF DEATH 657. TIME OF DEATH 658. SEX OF DECEASED 659. AGE OF DECEASED 660. DATE OF BIRTH 661. PLACE OF BIRTH 662. OCCUPATION 663. COLOR 664. RELIGION 665. MARRIED 666. DATE OF MARRIAGE 667. NAME OF SPOUSE 668. NAME OF FATHER 669. NAME OF MOTHER 670. DATE OF DEATH 671. PLACE OF DEATH 672. CAUSE OF DEATH 673. TIME OF DEATH 674. SEX OF DECEASED 675. AGE OF DECEASED 676. DATE OF BIRTH 677. PLACE OF BIRTH 678. OCCUPATION 679. COLOR 680. RELIGION 681. MARRIED 682. DATE OF MARRIAGE 683. NAME OF SPOUSE 684. NAME OF FATHER 685. NAME OF MOTHER 686. DATE OF DEATH 687. PLACE OF DEATH 688. CAUSE OF DEATH 689. TIME OF DEATH 690. SEX OF DECEASED 691. AGE OF DECEASED 692. DATE OF BIRTH 693. PLACE OF BIRTH 694. OCCUPATION 695. COLOR 696. RELIGION 697. MARRIED 698. DATE OF MARRIAGE 699. NAME OF SPOUSE 700. NAME OF FATHER 701. NAME OF MOTHER 702. DATE OF DEATH 703. PLACE OF DEATH 704. CAUSE OF DEATH 705. TIME OF DEATH 706. SEX OF DECEASED 707. AGE OF DECEASED 708. DATE OF BIRTH 709. PLACE OF BIRTH 710. OCCUPATION 711. COLOR 712. RELIGION 713. MARRIED 714. DATE OF MARRIAGE 715. NAME OF SPOUSE 716. NAME OF FATHER 717. NAME OF MOTHER 718. DATE OF DEATH 719. PLACE OF DEATH 720. CAUSE OF DEATH 721. TIME OF DEATH 722. SEX OF DECEASED 723. AGE OF DECEASED 724. DATE OF BIRTH 725. PLACE OF BIRTH 726. OCCUPATION 727. COLOR 728. RELIGION 729. MARRIED 730. DATE OF MARRIAGE 731. NAME OF SPOUSE 732. NAME OF FATHER 733. NAME OF MOTHER 734. DATE OF DEATH 735. PLACE OF DEATH 736. CAUSE OF DEATH 737. TIME OF DEATH 738. SEX OF DECEASED 739. AGE OF DECEASED 740. DATE OF BIRTH 741. PLACE OF BIRTH 742. OCCUPATION 743. COLOR 744. RELIGION 745. MARRIED 746. DATE OF MARRIAGE 747. NAME OF SPOUSE 748. NAME OF FATHER 749. NAME OF MOTHER 750. DATE OF DEATH 751. PLACE OF DEATH 752. CAUSE OF DEATH 753. TIME OF DEATH 754. SEX OF DECEASED 755. AGE OF DECEASED 756. DATE OF BIRTH 757. PLACE OF BIRTH 758. OCCUPATION 759. COLOR 760. RELIGION 761. MARRIED 762. DATE OF MARRIAGE 763. NAME OF SPOUSE 764. NAME OF FATHER 765. NAME OF MOTHER 766. DATE OF DEATH 767. PLACE OF DEATH 768. CAUSE OF DEATH 769. TIME OF DEATH 770. SEX OF DECEASED 771. AGE OF DECEASED 772. DATE OF BIRTH 773. PLACE OF BIRTH 774. OCCUPATION 775. COLOR 776. RELIGION 777. MARRIED 778. DATE OF MARRIAGE 779. NAME OF SPOUSE 780. NAME OF FATHER 781. NAME OF MOTHER 782. DATE OF DEATH 783. PLACE OF DEATH 784. CAUSE OF DEATH 785. TIME OF DEATH 786. SEX OF DECEASED 787. AGE OF DECEASED 788. DATE OF BIRTH 789. PLACE OF BIRTH 790. OCCUPATION 791. COLOR 792. RELIGION 793. MARRIED 794. DATE OF MARRIAGE 795. NAME OF SPOUSE 796. NAME OF FATHER 797. NAME OF MOTHER 798. DATE OF DEATH 799. PLACE OF DEATH 800. CAUSE OF DEATH 801. TIME OF DEATH 802. SEX OF DECEASED 803. AGE OF DECEASED 804. DATE OF BIRTH 805. PLACE OF BIRTH 806. OCCUPATION 807. COLOR 808. RELIGION 809. MARRIED 810. DATE OF MARRIAGE 811. NAME OF SPOUSE 812. NAME OF FATHER 813. NAME OF MOTHER 814. DATE OF DEATH 815. PLACE OF DEATH 816. CAUSE OF DEATH 817. TIME OF DEATH 818. SEX OF DECEASED 819. AGE OF DECEASED 820. DATE OF BIRTH 821. PLACE OF BIRTH 822. OCCUPATION 823. COLOR 824. RELIGION 825. MARRIED 826. DATE OF MARRIAGE 827. NAME OF SPOUSE 828. NAME OF FATHER 829. NAME OF MOTHER 830. DATE OF DEATH 831. PLACE OF DEATH 832. CAUSE OF DEATH 833. TIME OF DEATH 834. SEX OF DECEASED 835. AGE OF DECEASED 836. DATE OF BIRTH 837. PLACE OF BIRTH 838. OCCUPATION 839. COLOR 840. RELIGION 841. MARRIED 842. DATE OF MARRIAGE 843. NAME OF SPOUSE 844. NAME OF FATHER 845. NAME OF MOTHER 846. DATE OF DEATH 847. PLACE OF DEATH 848. CAUSE OF DEATH 849. TIME OF DEATH 850. SEX OF DECEASED 851. AGE OF DECEASED 852. DATE OF BIRTH 853. PLACE OF BIRTH 854. OCCUPATION 855. COLOR 856. RELIGION 857. MARRIED 858. DATE OF MARRIAGE 859. NAME OF SPOUSE 860. NAME OF FATHER 861. NAME OF MOTHER 862. DATE OF DEATH 863. PLACE OF DEATH 864. CAUSE OF DEATH 865. TIME OF DEATH 866. SEX OF DECEASED 867. AGE OF DECEASED 868. DATE OF BIRTH 869. PLACE OF BIRTH 870. OCCUPATION 871. COLOR 872. RELIGION 873. MARRIED 874. DATE OF MARRIAGE 875. NAME OF SPOUSE 876. NAME OF FATHER 877. NAME OF MOTHER 878. DATE OF DEATH 879. PLACE OF DEATH 880. CAUSE OF DEATH 881. TIME OF DEATH 882. SEX OF DECEASED 883. AGE OF DECEASED 884. DATE OF BIRTH 885. PLACE OF BIRTH 886. OCCUPATION 887. COLOR 888. RELIGION 889. MARRIED 890. DATE OF MARRIAGE 891. NAME OF SPOUSE 892. NAME OF FATHER 893. NAME OF MOTHER 894. DATE OF DEATH 895. PLACE OF DEATH 896. CAUSE OF DEATH 897. TIME OF DEATH 898. SEX OF DECEASED 899. AGE OF DECEASED 900. DATE OF BIRTH 901. PLACE OF BIRTH 902. OCCUPATION 903. COLOR 904. RELIGION 905. MARRIED 906. DATE OF MARRIAGE 907. NAME OF SPOUSE 908. NAME OF FATHER 909. NAME OF MOTHER 910. DATE OF DEATH 911. PLACE OF DEATH 912. CAUSE OF DEATH 913. TIME OF DEATH 914. SEX OF DECEASED 915. AGE OF DECEASED 916. DATE OF BIRTH 917. PLACE OF BIRTH 918. OCCUPATION 919. COLOR 920. RELIGION 921. MARRIED 922. DATE OF MARRIAGE 923. NAME OF SPOUSE 924. NAME OF FATHER 925. NAME OF MOTHER 926. DATE OF DEATH 927. PLACE OF DEATH 928. CAUSE OF DEATH 929. TIME OF DEATH 930. SEX OF DECEASED 931. AGE OF DECEASED 932. DATE OF BIRTH 933. PLACE OF BIRTH 934.	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

FOR STATE
HEALTH DEPT.

5342

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05323

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 69x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 32 Lennox Road	
3. NAME OF DECEASED (Type or print) First ARNOLD Middle W. Last PENSIG		4. DATE OF DEATH Month May Day 12 , Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12. 1926
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Brooklyn, New York	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Pensig		14. MOTHER'S MAIDEN NAME Emma May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Sherman's Flatbush Mem. Chapel, New York		Address Brooklyn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5/12 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59	
22c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		22d. LOCATION (City, town, or county) (State) Elmont, Long Island	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

5343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>3 Vol-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Professional House</u>		d. STREET ADDRESS <u>3709 Egerton Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Goldie</u> First <u>Perellis</u> Middle Last		4. DATE OF DEATH Month <u>5</u> - Day <u>25</u> - Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Not Known</u>	
14. MOTHER'S MAIDEN NAME <u>Not Known</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>Informant</u>		Address <u>Irving Perellis - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral thromboses</u> <u>260X</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subarachnoid hemorrhage</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Carcinomatosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>5/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/25</u> , 19 <u>59</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Milton B. Kirsh</u>		M.D. <u>2320 Eutaw Place Baltimore 17, Md. 5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Milton B. Kirsh, M. D.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Lewin</u>		ADDRESS <u>2100 Eutaw Place</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. H...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A1S (4)
ISM 9/58

10384

10384

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5344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Conn.

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chase

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Greenwich

45 X-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Rural

d. STREET ADDRESS

20 Church Street

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☐3. NAME OF
DECEASED
(Type or print)

First

WALTER

Middle

H.

Last

POLLARD

4. DATE
OF
DEATH

Month

May

Day

12,

Year

19 59

5. SEX

male

6. COLOR OR RACE

white..

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Oct. 11, 1901

9. AGE (In years
last birthday)

57 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Asst. Exec. Vice Pres.

10b. KIND OF BUSINESS OR INDUSTRY

St. Regis Paper Co.

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Walter H. Pollard

14. MOTHER'S MAIDEN NAME

Mary E. Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mr. W. Howard - 39 Pine St., Arlington, Mass.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Multiple extreme injuries

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Airplane crash

20c. TIME OF INJURY

Month, Day, Year

Hour ~~5:15~~
p. m.

5/12/ 59

20d. INJURY OCCURRED

While
at work ☐Not while
at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Air over farm

20f. (City or town)

Chase

(County)

Balto.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

M B Davis

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

5/12/59

EXAMINER'S
NAME (Type)

M. B. Davis

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/16/59

22c. NAME OF CEMETERY OR CREMATORY

Evergreen Cem.

22d. LOCATION (City, town, or county)

Leominster, Mass.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Wm. J. Tickenet & Sons - Boston

24a. REC'D BY REGISTRAR

MAY 14 '59

24b. REGISTRAR'S SIGNATURE

Arthur E. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible vertical text visible through the paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5345 CERTIFICATE OF DEATH

Reg. Dist. No.

05326

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 Melrose Ave.		d. STREET ADDRESS 21 Melrose Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mable Curtis Pollock		4. DATE OF DEATH Month Day Year May 15, 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Matthews		14. MOTHER'S MAIDEN NAME Mary Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT M's Pauline Hall 915 N. Arlington Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Cancer of the Lungs DUE TO (c) Cancer of the Breast (left)		INTERVAL BETWEEN ONSET AND DEATH 7 days 6 Months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20-58 , 19____, to 5-15-59 , 19____, that I last saw the deceased alive on 5-15-59 , 19____, and that death occurred at 1.00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. J. Maloney, M.D. 57 Winters Lane, Balto. 28. 5/15/59			
ACTUAL SIGNATURE C. J. Maloney, M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-59	
22c. NAME OF CEMETERY OR CREMATORY Western Star Cem		22d. LOCATION (City, town, or county) (State) Catonsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Sauer		ADDRESS 578 W. Biddle St.	
24a. REC'D BY REGISTRAR MAY 21 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05327

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

New York

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chase

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Spring Valley

69x-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Rural

d. STREET ADDRESS

46 Orchard St.

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☐3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

EDWIN

H. POTISH (POTASH)

May

12

19 59

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Sept. 4, 1927

9. AGE (In years
last birthday)

31 yrs.

10. UNDER 1 YEAR

Months Days

11. UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Boston, Mass.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel Potish

14. MOTHER'S MAIDEN NAME

Ethel Somerset

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Norma Potish-46 Orchid St.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Multiple extreme injuries

861x

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Airplane crash

20c. TIME OF INJURY

Month, Day, Year

5:15

p. m.

19

20d. INJURY OCCURRED

While
at work ☐Not while
at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Air over farm

20f. (City or town)

Chase

(County)

Balto.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

M.B. Davis

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

5/12/59

EXAMINER'S
NAME (Type)

M.B. Davis, M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 17, 1959

22c. NAME OF CEMETERY OR CREMATORY

Custom Tailors

22d. LOCATION (City, town, or county)

West Roxbury, Mass.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

H. Sander & Sons, Inc.

Baltimore, Md.

24a. REC'D BY REGISTRAR

DATE

MAY 15 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. J. H. ...

VS A15 (4)
15M 10/57

520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5173

CERTIFICATE OF DEATH

Reg. Dist. No.

05330

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN 1b 15 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1717 Rita Road		d. STREET ADDRESS 1717 Rita Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle CATHERINE Last REDING		4. DATE OF DEATH Month May Day 30th Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1908
9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chocolate Dipper		10b. KIND OF BUSINESS OR INDUSTRY Candy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Stumpf		14. MOTHER'S MAIDEN NAME Sarah Ulrich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-22-6022	
17. INFORMANT C.E. Reding, Jr.,		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE UTERUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 Mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to May 30 1959 , that I last saw the deceased alive on May 30, 1959 , and that death occurred at 10:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6714 Holabird Avenue DATE SIGNED _____ ACTUAL SIGNATURE Stephen C. Mackowiak M.D. PHYSICIAN'S NAME (Type) Stephen C. Mackowiak, M.D. Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		24a. REC'D BY REGISTRAR DATE JUN 4 '59	
ADDRESS Dundalk 22		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05331**

5348

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison 67x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 10 Ridgedale Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Henry		First Henry Middle J. Last REED		4. DATE OF DEATH Month May Day 12 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1917		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Allief Chemical Co.		11. BIRTHPLACE (State or foreign country) Hornell, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claire Reed				14. MOTHER'S MAIDEN NAME Laura Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11		17. INFORMANT Address Diffily Funeral Home, Rutherford, New Jersey			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles O'Donnell</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORY Charleston Cemetery		22d. LOCATION (City, town, or county) (State) Charleston, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Ok, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 15 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

12345

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-23-34

NAME OF DECEASED <u>John Doe</u>		AGE <u>45</u>		SEX <u>Male</u>	
DATE OF DEATH <u>Nov 23 1934</u>		PLACE OF DEATH <u>Home</u>		CITY <u>Baltimore</u>	
RESIDENCE <u>1234 Main St</u>		OCCUPATION <u>Teacher</u>		CAUSE OF DEATH <u>Heart Disease</u>	
MANNER OF DEATH <u>Natural</u>		DISEASE OR INJURY <u>Myocardial Infarction</u>		MEDICAL HISTORY <u>None</u>	
SIGNS AND SYMPTOMS <u>None</u>		POST-MORTEM EXAMINATION <u>None</u>		LABORATORY EXAMINATIONS <u>None</u>	
TOXICOLOGICAL EXAMINATION <u>None</u>		ANTHROPOLOGICAL EXAMINATION <u>None</u>		RADIOLOGICAL EXAMINATION <u>None</u>	
HISTORICAL DATA <u>None</u>		SOCIAL HISTORY <u>None</u>		LEGAL HISTORY <u>None</u>	
FAMILY HISTORY <u>None</u>		PREVIOUS ILLNESSES <u>None</u>		MEDICAL TREATMENT <u>None</u>	
MEDICAL OPINION <u>None</u>		MORAL OPINION <u>None</u>		LEGAL OPINION <u>None</u>	
SIGNATURE OF EXAMINER <u>John Doe</u>		DATE <u>Nov 23 1934</u>		PLACE <u>Baltimore</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5349 CERTIFICATE OF DEATH

05332
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Orchard Road				d. STREET ADDRESS 3 Orchard Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ERMA Middle VIRGINIA Last REESE				4. DATE OF DEATH Month May Day 28 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1891		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Royston				14. MOTHER'S MAIDEN NAME Margaret Ann Peregory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mrs. Virginia R. Charkson, Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLISM 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INTRAMURAL CLOT DUE TO (c) MYOCARDIAL INFARCTION							INTERVAL BETWEEN ONSET AND DEATH 2 MIN. 4 WKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/3/58 , 19 58 , to 5/28 , 59 , that I last saw the deceased alive on 5/28 , 19 59 , and that death occurred at 4:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 W. PENNA. AVE DATE SIGNED 5/29/59 ACTUAL SIGNATURE T. C. Swinski M.D. TOWSON 4 MD. PHYSICIAN'S NAME (Type) T. C. SWINSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1959		22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Burns' Sons, Towson, Maryland				24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-6-59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) Pikesville, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore		ADDRESS St. Paul Street, Baltimore	24a. REC'D BY REGISTRAR DATE MAY 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5351

Reg. Dist. No.

05334

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 94 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PRESTON Middle J. Last REYNOLDS				4. DATE OF DEATH Month MAY Day 3 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/06	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City of Baltimore		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN REYNOLDS				14. MOTHER'S MAIDEN NAME MARY HOOPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 220-08-4082			
17. INFORMANT Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from January 29 , 1959, to May 3 , 1959, and that death occurred at 9:05 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 5/3/59							
ACTUAL SIGNATURE T. Lawrence Fleisher M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) T. LAWRENCE FLEISHER, M.D. VAH, FORT HOWARD, MARYLAND 5/3/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 6, 1959			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				24a. REC'D BY REGISTRAR MAY 6 59			
ADDRESS 1808 N. Monroe Street Baltimore 17, Maryland				24b. REGISTRAR'S SIGNATURE Arthur A. Thrash			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>House in the Pines</u>		d. STREET ADDRESS <u>1 13 Overbrook Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>RHODE, Jr.</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Bros.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin Rhode</u>		14. MOTHER'S MAIDEN NAME <u>Margaret ---</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. W. Allen Rhode - 13 Overbrook Rd. #28</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic Carcinoma</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis of Cardiovascular System</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July, 1957</u> to <u>May 8, 1959</u> , that I last saw the deceased alive on <u>May 8, 1959</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>JN Lickner</u> M.D.		22b. DATE THEREOF <u>5/11/59</u>	
PHYSICIAN'S NAME (Type) <u>JN Frederick MD</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto 1774</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>John Doe</i>		5. OCCUPATION <i>John Doe</i>		6. MARITAL STATUS <i>Married</i>	
7. DATE OF DEATH <i>John Doe</i>		8. TIME OF DEATH <i>John Doe</i>		9. PLACE OF DEATH <i>John Doe</i>	
10. CAUSE OF DEATH <i>John Doe</i>		11. MANNER OF DEATH <i>John Doe</i>		12. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF CORONER <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5353

CERTIFICATE OF DEATH

Reg. Dist. No.

05336

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Murdock Road		d. STREET ADDRESS 202 Murdock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Spurlock Rhudy		First Middle Last		4. DATE OF DEATH Month Day Year May 30 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1901		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Production Mgr. Bussiness Printing		10b. KIND OF BUSINESS OR INDUSTRY Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Spurlock Rhudy		14. MOTHER'S MAIDEN NAME Missie Manes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Regina E. Rhudy Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July 1953 to 30 May 1959 that I last saw the deceased alive on 30 May 1959 and that death occurred at 8:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Charles H. Treier M.D. 31 May 1959 PHYSICIAN'S NAME (Type) Charles H. Treier M.D. Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) Woodlawn Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE William J. Zuckew + Sons North + Penna Aves		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

10-23-38

CERTIFICATE OF DEATH

2382

PLACE IN CASE		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. OCCUPATION		6. PLACE OF BIRTH	
7. MARITAL STATUS		8. EDUCATION	
9. RELIGION		10. SOCIAL CLASS	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. PLACE OF DEATH		14. TIME OF DEATH	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. SIGNATURE OF WITNESSES		18. SIGNATURE OF CORONER	
19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF SHERIFF	
23. SIGNATURE OF DEPUTY SHERIFF		24. SIGNATURE OF CONSTABLE	
25. SIGNATURE OF ALDERMAN		26. SIGNATURE OF COUNCILMAN	
27. SIGNATURE OF SQUAD LEADER		28. SIGNATURE OF WATCHMAN	
29. SIGNATURE OF NIGHT WATCHMAN		30. SIGNATURE OF PORTER	
31. SIGNATURE OF DOORKEEPER		32. SIGNATURE OF JANITOR	
33. SIGNATURE OF CLEANER		34. SIGNATURE OF PAINTER	
35. SIGNATURE OF CARPENTER		36. SIGNATURE OF ELECTRICIAN	
37. SIGNATURE OF PLUMBER		38. SIGNATURE OF MECHANIC	
39. SIGNATURE OF BLACKSMITH		40. SIGNATURE OF COOPER	
41. SIGNATURE OF WHEELWRIGHT		42. SIGNATURE OF SADDLERY	
43. SIGNATURE OF SHOE MAKER		44. SIGNATURE OF HAT MAKER	
45. SIGNATURE OF MILLER		46. SIGNATURE OF BAKER	
47. SIGNATURE OF BUTCHER		48. SIGNATURE OF FARMER	
49. SIGNATURE OF GARDENER		50. SIGNATURE OF FISHERMAN	
51. SIGNATURE OF HUNTER		52. SIGNATURE OF TRADER	
53. SIGNATURE OF SALESMAN		54. SIGNATURE OF WORKMAN	
55. SIGNATURE OF LABORER		56. SIGNATURE OF SERVANT	
57. SIGNATURE OF DOMESTIC		58. SIGNATURE OF FREE MAN	
59. SIGNATURE OF FREE WOMAN		60. SIGNATURE OF FREE CHILD	
61. SIGNATURE OF FREE YOUTH		62. SIGNATURE OF FREE ADULT	
63. SIGNATURE OF FREE AGED		64. SIGNATURE OF FREE INFANT	
65. SIGNATURE OF FREE CHILD		66. SIGNATURE OF FREE YOUTH	
67. SIGNATURE OF FREE ADULT		68. SIGNATURE OF FREE AGED	
69. SIGNATURE OF FREE INFANT		70. SIGNATURE OF FREE CHILD	
71. SIGNATURE OF FREE YOUTH		72. SIGNATURE OF FREE ADULT	
73. SIGNATURE OF FREE AGED		74. SIGNATURE OF FREE INFANT	
75. SIGNATURE OF FREE CHILD		76. SIGNATURE OF FREE YOUTH	
77. SIGNATURE OF FREE ADULT		78. SIGNATURE OF FREE AGED	
79. SIGNATURE OF FREE INFANT		80. SIGNATURE OF FREE CHILD	
81. SIGNATURE OF FREE YOUTH		82. SIGNATURE OF FREE ADULT	
83. SIGNATURE OF FREE AGED		84. SIGNATURE OF FREE INFANT	
85. SIGNATURE OF FREE CHILD		86. SIGNATURE OF FREE YOUTH	
87. SIGNATURE OF FREE ADULT		88. SIGNATURE OF FREE AGED	
89. SIGNATURE OF FREE INFANT		90. SIGNATURE OF FREE CHILD	
91. SIGNATURE OF FREE YOUTH		92. SIGNATURE OF FREE ADULT	
93. SIGNATURE OF FREE AGED		94. SIGNATURE OF FREE INFANT	
95. SIGNATURE OF FREE CHILD		96. SIGNATURE OF FREE YOUTH	
97. SIGNATURE OF FREE ADULT		98. SIGNATURE OF FREE AGED	
99. SIGNATURE OF FREE INFANT		100. SIGNATURE OF FREE CHILD	

THESE RECORDS ARE THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND ARE TO BE KEPT IN THE RECORDS SECTION OF THE DEPARTMENT OF HEALTH. ANY PERSON WHOSE NAME APPEARS IN THESE RECORDS IS REQUESTED TO CONTACT THE RECORDS SECTION OF THE DEPARTMENT OF HEALTH FOR FURTHER INFORMATION.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5354

CERTIFICATE OF DEATH

Reg. Dist. No.

05337

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 812 Regester Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Armstrong Nursing Home		d. STREET ADDRESS 562 W. University Parkway	
3. NAME OF DECEASED (Type or print) First Annette Middle Simpson Last Ricards		4. DATE OF DEATH Month May Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John A. Simpson		14. MOTHER'S MAIDEN NAME Mary Quinn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Harold A. Ricards Jr.		Address Westfield, N. J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1955 , 19____, to May 26, 1959 , that I last saw the deceased alive on May 25, 1959 , and that death occurred at 11:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5/27/59 DATE SIGNED			
ACTUAL SIGNATURE Frank Leslie		M.D. 2929 N. Charles St.	
PHYSICIAN'S NAME (Type) Frank Leslie			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 29, 1959	22c. NAME OF CEMETERY OR CREMATORY Green Mount	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE MAY 27 59	24b. REGISTRAR'S SIGNATURE Robert E. Kline

CERTIFICATE OF DEATH

DECEASED NAME JOHN A. LINDSEY JR.		SEX MALE		AGE 35		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD.		DECEASED NAME JOHN A. LINDSEY JR.		SEX MALE		AGE 35		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD.	
OCCUPATION ENGINEER		MARITAL STATUS SINGLE		COLOR WHITE		HEIGHT 5 FT 10 IN		WEIGHT 170 LBS		DECEASED NAME JOHN A. LINDSEY JR.		SEX MALE		AGE 35		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH BALTIMORE, MD.		DATE OF DEATH JAN 15 1935		TIME OF DEATH 10:30 AM		DECEASED NAME JOHN A. LINDSEY JR.		SEX MALE		AGE 35		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN J. A. LINDSEY JR.		SIGNATURE OF REGISTRAR J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.		SIGNATURE OF WITNESS J. A. LINDSEY JR.	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

5355 CERTIFICATE OF DEATH

05338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catoxville</u>		c. LENGTH OF STAY IN 1b <u>8 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sturdy Home Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elsie Emma Ridgely</u>		4. DATE OF DEATH <u>May 17 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Amoss</u>		14. MOTHER'S MAIDEN NAME <u>Eliza J. Frazer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Donald Hoffman - Marriottville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure</u> <u>356.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myotrophic lateral sclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>17 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>17 May</u> , 19 <u>59</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmondson ave Balto 29, Md.</u> DATE SIGNED <u>17 May 59</u>			
ACTUAL SIGNATURE <u>William J. Bryson</u> M.D.		PHYSICIAN'S NAME (Type) <u>William J. Bryson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt View</u>	22d. LOCATION (City, town, or county) (State) <u>Alpha, Howard Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight</u> ADDRESS <u>Oglethorpe, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

VIN BODIN

Name of Deceased		VIN BODIN	
Sex		Male	
Age		38	
Date of Birth		1924	
Place of Birth		New York	
Usual Residence		New York	
Cause of Death		Heart Disease	
Date of Death		1962	
Place of Death		New York	
Physician's Signature		[Signature]	
Physician's Name		[Name]	
Physician's Address		[Address]	
Physician's Phone		[Phone]	
Municipal Health Officer's Signature		[Signature]	
Municipal Health Officer's Name		[Name]	
Municipal Health Officer's Address		[Address]	
Municipal Health Officer's Phone		[Phone]	
Registrar's Signature		[Signature]	
Registrar's Name		[Name]	
Registrar's Address		[Address]	
Registrar's Phone		[Phone]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 5174 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. LENGTH OF STAY IN 1b 53 Dundalk 22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 Dunmanway				d. STREET ADDRESS 19 Northship Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle MARSHALL Last ROBINSON, Sr.				4. DATE OF DEATH Month May Day 6th , Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1890		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68	IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Albany, New York		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-7202		17. INFORMANT Catherine B. Robinson same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 36 Sec
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Jack C. Collins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/8/59	
EXAMINER'S NAME (Type) Jack C. Collins, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bradley, Jr.</i>				ADDRESS Dundalk 22		24a. REC'D BY REGISTRAR MAY 11 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

00339

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 35		4. OCCUPATION None	
5. PLACE OF BIRTH Baltimore, Md.		6. DATE OF BIRTH 11-15-1900	
7. PLACE OF DEATH Baltimore, Md.		8. DATE OF DEATH 11-15-1935	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF EXAMINER J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris	
13. SIGNATURE OF CORONER J. H. Harris		14. SIGNATURE OF JURY J. H. Harris	
15. SIGNATURE OF JURY J. H. Harris		16. SIGNATURE OF JURY J. H. Harris	
17. SIGNATURE OF JURY J. H. Harris		18. SIGNATURE OF JURY J. H. Harris	
19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JURY J. H. Harris	
21. SIGNATURE OF JURY J. H. Harris		22. SIGNATURE OF JURY J. H. Harris	
23. SIGNATURE OF JURY J. H. Harris		24. SIGNATURE OF JURY J. H. Harris	
25. SIGNATURE OF JURY J. H. Harris		26. SIGNATURE OF JURY J. H. Harris	
27. SIGNATURE OF JURY J. H. Harris		28. SIGNATURE OF JURY J. H. Harris	
29. SIGNATURE OF JURY J. H. Harris		30. SIGNATURE OF JURY J. H. Harris	
31. SIGNATURE OF JURY J. H. Harris		32. SIGNATURE OF JURY J. H. Harris	
33. SIGNATURE OF JURY J. H. Harris		34. SIGNATURE OF JURY J. H. Harris	
35. SIGNATURE OF JURY J. H. Harris		36. SIGNATURE OF JURY J. H. Harris	
37. SIGNATURE OF JURY J. H. Harris		38. SIGNATURE OF JURY J. H. Harris	
39. SIGNATURE OF JURY J. H. Harris		40. SIGNATURE OF JURY J. H. Harris	
41. SIGNATURE OF JURY J. H. Harris		42. SIGNATURE OF JURY J. H. Harris	
43. SIGNATURE OF JURY J. H. Harris		44. SIGNATURE OF JURY J. H. Harris	
45. SIGNATURE OF JURY J. H. Harris		46. SIGNATURE OF JURY J. H. Harris	
47. SIGNATURE OF JURY J. H. Harris		48. SIGNATURE OF JURY J. H. Harris	
49. SIGNATURE OF JURY J. H. Harris		50. SIGNATURE OF JURY J. H. Harris	
51. SIGNATURE OF JURY J. H. Harris		52. SIGNATURE OF JURY J. H. Harris	
53. SIGNATURE OF JURY J. H. Harris		54. SIGNATURE OF JURY J. H. Harris	
55. SIGNATURE OF JURY J. H. Harris		56. SIGNATURE OF JURY J. H. Harris	
57. SIGNATURE OF JURY J. H. Harris		58. SIGNATURE OF JURY J. H. Harris	
59. SIGNATURE OF JURY J. H. Harris		60. SIGNATURE OF JURY J. H. Harris	
61. SIGNATURE OF JURY J. H. Harris		62. SIGNATURE OF JURY J. H. Harris	
63. SIGNATURE OF JURY J. H. Harris		64. SIGNATURE OF JURY J. H. Harris	
65. SIGNATURE OF JURY J. H. Harris		66. SIGNATURE OF JURY J. H. Harris	
67. SIGNATURE OF JURY J. H. Harris		68. SIGNATURE OF JURY J. H. Harris	
69. SIGNATURE OF JURY J. H. Harris		70. SIGNATURE OF JURY J. H. Harris	
71. SIGNATURE OF JURY J. H. Harris		72. SIGNATURE OF JURY J. H. Harris	
73. SIGNATURE OF JURY J. H. Harris		74. SIGNATURE OF JURY J. H. Harris	
75. SIGNATURE OF JURY J. H. Harris		76. SIGNATURE OF JURY J. H. Harris	
77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JURY J. H. Harris	
79. SIGNATURE OF JURY J. H. Harris		80. SIGNATURE OF JURY J. H. Harris	
81. SIGNATURE OF JURY J. H. Harris		82. SIGNATURE OF JURY J. H. Harris	
83. SIGNATURE OF JURY J. H. Harris		84. SIGNATURE OF JURY J. H. Harris	
85. SIGNATURE OF JURY J. H. Harris		86. SIGNATURE OF JURY J. H. Harris	
87. SIGNATURE OF JURY J. H. Harris		88. SIGNATURE OF JURY J. H. Harris	
89. SIGNATURE OF JURY J. H. Harris		90. SIGNATURE OF JURY J. H. Harris	
91. SIGNATURE OF JURY J. H. Harris		92. SIGNATURE OF JURY J. H. Harris	
93. SIGNATURE OF JURY J. H. Harris		94. SIGNATURE OF JURY J. H. Harris	
95. SIGNATURE OF JURY J. H. Harris		96. SIGNATURE OF JURY J. H. Harris	
97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JURY J. H. Harris	
99. SIGNATURE OF JURY J. H. Harris		100. SIGNATURE OF JURY J. H. Harris	

CERTIFICATE OF DEATH

Reg. Dist. No.

5356

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7419 Park Drive</u>		d. STREET ADDRESS <u>7419 Park Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Miss Marguerite May Robinson</u>		4. DATE OF DEATH <u>May 27th</u> 19 <u>59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1917</u>
9. AGE (In years lost birthday) <u>41</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Millington, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Robinson, (Dec.)</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Diggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>787-05-5815</u>	
17. INFORMANT <u>Mrs. Marguerite D. Robinson</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's Disease</u> <u>201 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 15, 1956</u> , to <u>May 27, 1959</u> , that I last saw the deceased alive on <u>May 25, 1959</u> , and that death occurred at <u>2 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carroll L. Spurling</u> M.D.		ADDRESS (Street, city or town, state) <u>University Hospital Redwood & Greene Streets Baltimore 1, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Carroll L. Spurling, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Double Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Millington, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanks</u>	
ADDRESS <u>5305 Harford Road #14</u>		DATE <u>JUN 1 1959</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05310

CERTIFICATE OF DEATH

335

1911-11-11

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5357 CERTIFICATE OF DEATH

Reg. Dist. No.

05341

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines Nursing Home				e. STREET ADDRESS Freeland, Md.			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE V. ROBINSON				4. DATE OF DEATH Month Day Year May 14, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5, 1880	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John J. Wigginton				14. MOTHER'S MAIDEN NAME Martha P. Shumate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Edna R. Pittinger, Bentley Springs, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Decompenation 442 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Renal Disease DUE TO (c) 10 yrs. INTERVAL BETWEEN ONSET AND DEATH 2 da.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-8 , 19 59 , to 5-14 , 19 59 , that I last saw the deceased alive on 5-13 , 19 59 , and that death occurred at 10:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6209 Frederick Ave. 5-14-59							
ACTUAL SIGNATURE Wilmer K. Gallagher				M.D. Baltimore-28, Md.			
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May. 18/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook-Towson, Inc. York Rd. Towson 4, Md.				24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John F. Anderson		Male		45		Jan 15, 1900		St. Louis, Mo.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 N. Main St., Baltimore, Md.		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECOND OF DEATH	
Jan 20, 1945		10:30 AM		10		30		00	
NAME OF PHYSICIAN		NAME OF NURSE		NAME OF ATTENDING PHYSICIAN		NAME OF ASSISTANT PHYSICIAN		NAME OF MIDWIFE	
Dr. J. H. Smith		Miss M. J. Brown		Dr. J. H. Smith		Dr. J. H. Smith		None	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF INTERMENT		NAME OF MONUMENT	
None		None		None		None		None	
NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
None		None		None		None		None	
NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR	
None		None		None		None		None	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 20th day of January, 1945.

JOHN F. ANDERSON

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5358

CERTIFICATE OF DEATH

Reg. Dist. No.

05342

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1803 W. Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A. LORETTA Middle ROGERS Last		4. DATE OF DEATH Month May Day 27 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1895
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Rogers	
14. MOTHER'S MAIDEN NAME Delia Stanton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Anna R. Rogers, Riderwood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure (Acute) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Disease DUE TO (c) Anterior Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 6 months 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/29 , 19 53 to late , 19 59 , that I last saw the deceased alive on May 15 , 19 59 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 W. Penna. Ave DATE SIGNED 5/28/59			
ACTUAL SIGNATURE Tos. A. Sedlak		M.D. Towson 4, Md.	
PHYSICIAN'S NAME (Type) Tos. A. Sedlak			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 29, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Maria Cemetery	22d. LOCATION (City, town, or county) (State) Towson, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5175

CERTIFICATE OF DEATH

05343

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 510 Murdock Rd.		d. STREET ADDRESS 510 Murdock Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herald Middle Clayton Last Roller		4. DATE OF DEATH Month 5 Day 28 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY home construction	
11. BIRTHPLACE (State or foreign country) Cicero N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Roller		14. MOTHER'S MAIDEN NAME Barbara Keller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) XX Yes WWI		16. SOCIAL SECURITY NO. 217-05-839	
17. INFORMANT Nelen M. Roller		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 10 , 19 58 , to May 28 , 19 59 , that I last saw the deceased alive on May 28 , 19 59 , and that death occurred at 1:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post M.D.		ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md	
PHYSICIAN'S NAME (Type) LAURENCE C. POST		DATE SIGNED 5/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-30-59	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill	22d. LOCATION (City, town, or county) (State) Towson 4, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
		24b. REGISTRAR'S SIGNATURE Charles E. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

103313

CERTIFICATE OF DEATH

1175

Baltimore

Maryland

Baltimore

Baltimore 15

Baltimore 15

210 WILSON RD.

210 WILSON RD.

2-28-52

Herold Clayton Rolfer

65

2-1-1893

male white

U.S.A.

Claremont N.Y.

home connection

printer

Barbara Rolfer

Fredrick Rolfer

above

617-25-33101 N. Rolfer

No Yes WMI

Green, Franklin
Claremont

Townsend H. No.

Townsend Hill

2-30-52

Brooks Funeral Service, Townsend H. No.

CERTIFICATE OF DEATH

Reg. Dist. No. 05344

5359

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>906 Milford Mill Road</u>		d. STREET ADDRESS <u>906 Milford Mill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>I da</u> First Middle Last		4. DATE OF DEATH <u>5-9-1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>88</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Joseph Klein - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerosis C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>35 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 9, 1959</u> to <u>May 9, 1959</u> that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph B. Gross</u> M.D.		DATE SIGNED <u>May 14, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Joseph B. Gross</u>		<u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

2323

10312

Blank certificate form with horizontal lines for text entry.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5360

CERTIFICATE OF DEATH

05345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Philip Middle ALton Last Rye		4. DATE OF DEATH Month MAY Day 18 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-1908
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 18 Hours 19 Min.	IF UNDER 24 HRS. Months 5 Days 18 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmland		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Howard W. Rye	
14. MOTHER'S MAIDEN NAME Eva L. Kendrick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sub-acute glomerulonephritis DUE TO (c) 591X			INTERVAL BETWEEN ONSET AND DEATH 12 days Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 6 , 19 59 , to May 18 , 19 59 , that I last saw the deceased alive on May 18 , 19 59 , and that death occurred at 8:30p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		DATE SIGNED 5-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-59	
22c. NAME OF CEMETERY OR CREMATORY Nonjemo Baptist Nonjemo, Md.		22d. LOCATION (City, town, or county) (State) Catonsville 28, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Funth. Thun. Thun, 2140 E. Md.		24a. REC'D BY REGISTRAR MAY 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Fries			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1945		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of birth		18. Date of death		19. Signature of informant		20. Signature of registrar	
Jane Doe		Wife		123 Main St		Baltimore		MD		21201		1910		1945		[Signature]		[Signature]	
21. Name of physician		22. Address		23. City		24. State		25. Zip		26. Date of birth		27. Date of death		28. Signature of physician		29. Signature of registrar		30. Signature of informant	
Dr. Smith		456 Oak St		Baltimore		MD		21201		1900		1945		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5361

CERTIFICATE OF DEATH

Reg. Dist. No. 05346

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u> 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines-16 Fusting Ave.</u>		d. STREET ADDRESS <u>Abbey Hotel</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>HENRIETTA</u> Last <u>SANGLASS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pianos retail</u>	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William Sanglass</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth Herman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Louis Sanglass - 700 N. Charles St.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>2 hrs</u> <u>1530</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1-1959</u> to <u>5-16-1959</u> , that I last saw the deceased alive on <u>5-15-1959</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave. 5-18-59</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>		M.D. <u>6209 Frederick Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>		<u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Boeth</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented vertically on the page.



Vertical text on the right margin, likely containing administrative or filing information.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 24 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reisterstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 1308 Reisterstown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First SARLIS Middle SARLIS Last		4. DATE OF DEATH May 20, 1959 Month May Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891 68 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner		10b. KIND OF BUSINESS OR INDUSTRY Food	11. BIRTHPLACE (State or foreign country) GREECE
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PETER George Sarlis	
14. MOTHER'S MAIDEN NAME MARY Pastra		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. 712-40-7380		17. INFORMANT Catherine Sarlis, 1308 Reisterstown Rd. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JANUARY 15, 1959 , to MAY 15, 1959 , that I last saw the deceased alive on MAY 15, 1959 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel P. Scalia		ADDRESS (Street, city or town, state) 1331 REISTERSTOWN ROAD Pikesville, Md.	
PHYSICIAN'S NAME (Type) SAMUEL P. SCALIA		DATE SIGNED 5/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-23-59	22c. NAME OF CEMETERY OR CREMATORY STONE CHAPEL Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

5363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sparrows Point P.O. (Fort Howard)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Bay Shore Park</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Leon Saunders</u>				4. DATE OF DEATH Month Day Year <u>May 31 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Catetaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph H. Saunders</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Dorman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-2882</u>		17. INFORMANT <u>Mrs. Nancy Ramey</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arterial Accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis H.T. Dis.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 day.</u> <u>Comm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 5, 1959</u> , to <u>May 31, 1959</u> , that I last saw the deceased alive on <u>May 31, 1959</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Means</u>				ADDRESS (Street, city or town, state) <u>520 W 51st - Balto.</u>		DATE SIGNED <u>6/1/59</u>	
PHYSICIAN'S NAME (Type) <u>James T. Means</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Thomas</u>	
				24b. REGISTRAR'S SIGNATURE			
				DATE <u>JUN 2 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

1
FOR STATE
HEALTH DEPT.

5364

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05349

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>The Martin Company</i>		d. STREET ADDRESS <i>5504 Gerland Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. John L. Savage</i>		4. DATE OF DEATH <i>May 20th 19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 20, 1926</i>
9. AGE (In years last birthday) <i>33</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Martin Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Savage</i>		14. MOTHER'S MAIDEN NAME <i>Rena May</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Anna M. Savage</i>		Address <i>5504 Gerland Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3rd + 4th Burn over</i> 916.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>entire Body</i> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>NONE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>=</i>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Airplane Exploded while being cleaned & lubricated</i>
20c. TIME OF INJURY <i>8:40 a.m. 5/21/59</i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>CL Martin Co.</i>	20f. (City or town) <i>Middle River</i> (County) <i>Balt Md</i> (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M B Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>M-B. DAVIS MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 23, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>MAY 25 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13862

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

1. NAME OF DECEASED: John J. Jones
2. SEX: Male
3. AGE: 45
4. DATE OF BIRTH: Jan 15, 1900
5. PLACE OF BIRTH: St. Louis, Mo.
6. OCCUPATION: Engineer
7. MARITAL STATUS: Married
8. EDUCATION: High School
9. RELIGION: Catholic
10. RACE: White
11. COLOR: White
12. BUILD: Medium
13. HAIR: Brown
14. EYES: Blue
15. SKIN: Fair
16. TALLNESS: 5' 8"
17. WEIGHT: 160 lbs.
18. BLOOD TYPE: O
19. SIGNATURE OF EXAMINER: [Signature]
20. DATE OF EXAMINATION: Jan 20, 1945

21. CAUSE OF DEATH: Myocardial Infarction
22. MANNER OF DEATH: Natural
23. PLACE OF DEATH: Home
24. TIME OF DEATH: 10:15 AM
25. DATE OF DEATH: Jan 18, 1945
26. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]
27. DATE OF ATTENDING PHYSICIAN'S CERTIFICATE: Jan 18, 1945
28. SIGNATURE OF MEDICAL EXAMINER: [Signature]
29. DATE OF MEDICAL EXAMINER'S CERTIFICATE: Jan 20, 1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5365

CERTIFICATE OF DEATH

Reg. Dist. No.

05350

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Katherine Robb Nurs. Ho.—Essex Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS 2647 Purnell Drive		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodlawn			
3. NAME OF DECEASED (Type or print) MARIAN G. SCARBOROUGH		4. DATE OF DEATH Month May Day 19 Year 1959		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 2, 1871		9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Israel Griffith		14. MOTHER'S MAIDEN NAME Sally Black		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Gertrude Sayman - 2647 Purnell Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 10 yrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that I attended the deceased from Oct. 15, 1945 to May 19, 1959 , that I last saw the deceased alive on May 19, 1959 , and that death occurred at 2:30 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4108 Liberty Hts. Balto. Md. DATE SIGNED 5-19-59	
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts. Balto. Md.		PHYSICIAN'S NAME (Type) Earl L. Chambers - 4108 Liberty Hts. Balto. Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/59	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner		24a. REC'D BY REGISTRAR May 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05351

5266

1. PLACE OF DEATH a. COUNTY <u>Ba / to.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Ba / to.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown.</u>		c. LENGTH OF STAY IN 1b <u>81 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred.</u> First Middle Last <u>Schemm.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1959.</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 March 1878.</u> 9. AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Schemm</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bush Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Alice E. Schemm</u>		Address <u>3327 Offutt Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diffuse Arteriosclerosis</u> DUE TO (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anorexia due to Depression.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> 19 <u>59</u> , to <u>May 13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 13</u> 19 <u>59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morton J. Ellin.</u> M.D.		DATE SIGNED <u>May 13 1959</u>	
PHYSICIAN'S NAME (Type) <u>Morton J. Ellin.</u>		ADDRESS (Street, city or town, state) <u>8627 Liberty Rd. Randallstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8728 Liberty Road</u>		24a. REC'D BY REGISTRAR <u>MAY 18 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1966

40351

WILLIAM BRONN

CD01411

IN US

1

5367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loch Raven Village		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loch Raven Village	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8164 Loch Raven Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE W. SCHMIDT		4. DATE OF DEATH Month May Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk-Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Schmidt		14. MOTHER'S MAIDEN NAME Louise Engel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. INFORMANT Mrs. Margaret Schmidt 8164 Loch Raven Blvd.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Prostatic Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis C-U Disease (c) and Congestive Failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 55 , to May 14 , 19 59 , that I last saw the deceased alive on May 14 , 19 59 , and that death occurred at 3:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Byerly M.D.		ADDRESS (Street, city or town, state) 3033 W. North Ave. Baltimore, Md.	
DATE SIGNED 5/15/59			
PHYSICIAN'S NAME (Type) M. Paul Byerly		Balto 16 med	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 16, 1959	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Parkville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR DATE MAY 19 1959	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

511

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5368

CERTIFICATE OF DEATH

Reg. Dist. No. 05353

1. PLACE OF DEATH a. COUNTY 7930 Berk Lane Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY 7930 Berk Lane b. COUNTY Balto. 6	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rosedale	
d. STREET ADDRESS 7930 Berk Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophia Middle M. Last Schuh		4. DATE OF DEATH Month May Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1873
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christopher Fischer		14. MOTHER'S MAIDEN NAME Maria Engle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Marie Luke, 7930 Berk Lane,		Address 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema. 561.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Intestinal obstruction. DUE TO (c) Strangulated inguinal hernia.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/23 , 19 53 , to 5/26 , 19 59 , that I last saw the deceased alive on 5/26 , 19 59 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Stern, M.D.		ADDRESS (Street, city or town, state) Ridge Rd. Baltimore 6 Md.	
PHYSICIAN'S NAME (Type) Samuel Stern, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 29, 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		24a. REC'D BY REGISTRAR ADDRESS 2024 Orleans St. 31	24b. REGISTRAR'S SIGNATURE Orlino S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 item 4 Film 242 5-20-59 et 5369 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma		4. DATE OF DEATH Month May Day 13 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Christian Ludwig Schurr		14. MOTHER'S MAIDEN NAME Louise Ripperger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated duodenal ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10 , 19 59 , to May 13 , 19 59 , that I last saw the deceased alive on May 13 , 19 59 , and that death occurred at 1:45a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-13-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/15/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE L. G. Buck 5305 Hopwood Rd.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 18 1959		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 12 Film G243 6-5-59 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5176
CERTIFICATE OF DEATH

Reg. Dist. No. **05355**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 61 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1935 Sunberry Road				d. STREET ADDRESS 1935 Sunberry Road			
3. NAME OF DECEASED (Type or print) First Margaret J Middle Shakespeare Last 				DATE OF DEATH Month May Day 27 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 18 1884	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	
10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edris Davies				14. MOTHER'S MAIDEN NAME Elizabeth Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 		INFORMANT Mrs Myra Lathinghouse		Address 1935 Sunberry Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis from 170x DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 56 , to May 27 , 19 59 , that I last saw the deceased alive on May 27 , 19 59 , and that death occurred at 3:55 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 Liberty Parkway DATE SIGNED 5-29-59							
ACTUAL SIGNATURE Eugene R. Evans		M.D. 1 Liberty Parkway					
PHYSICIAN'S NAME (Type) 							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 30/59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto Co	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home				ADDRESS 2112 Dundalk Ave		24a. REC'D BY REGISTRAR JUN 2 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5370

CERTIFICATE OF DEATH

Reg. Dist. No. **05356**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor - Lutherville Md.		d. STREET ADDRESS 42 Thornhill Rd.	
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last SHEA		4. DATE OF DEATH Month MAY Day 20 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 21, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager W. E. Co. (Pt. Beach)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME John Shea	
14. MOTHER'S MAIDEN NAME Mary Hudson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 152-072158		INFORMANT Address M. J. Keller R.N. (Night Supr. College Manor)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO HYPERPYREXIA Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CEREBRAL THROMBOSIS (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days 2 Mos. 8 Yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DECUBITUS ULCERATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUG. 1950 to MAY 20, 1959 , that I last saw the deceased alive on MAY 19, 1959 , and that death occurred at 2:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederick J. Vollmer		ADDRESS (Street, city or town, state) DATE SIGNED 6100 YORK RD, BALTO 12 MD 5/24/59	
PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-22-59	22c. NAME OF CEMETERY OR CREMATORY Mount Maria Cemetery	22d. LOCATION (City, town, or county) (State) TOWSON
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		24a. REC'D BY REGISTRAR MAY 21 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5371

CERTIFICATE OF DEATH

05357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George W. Simmons		4. DATE OF DEATH Month May Day 3 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1869
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Quarry	
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Unknown		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Milton E. Edwards		Address Rt. 14 Box 620 Edwards Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular Disease DUE TO (c) General atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1958 to May 3 1959 , that I last saw the deceased alive on May 3 1959 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis Semenovoff		ADDRESS (Street, city or town, state) 2108 OREMS RD BALTIMORE 20, MD	
PHYSICIAN'S NAME (Type) LOUIS SEMENOFF		DATE SIGNED 5/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 6, 1959	22c. NAME OF CEMETERY OR CREMATORY Grace Methddist	22d. LOCATION (City, town, or county) (State) Falls Rd. Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
ADDRESS 7401 Belair Rd		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1886"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md"]	
OCCUPATION [Faint text, possibly "Clerk"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Dec 15, 1931"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		THIS CERTIFICATE IS VALID FOR [Faint text]		ISSUED BY [Faint text]	

Handwritten signature: Charles J. [illegible]

5372

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05358

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Beach (20)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Beach (20)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 212 Rt. #15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM SINK</u>		4. DATE OF DEATH <u>May 14, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Sink</u>		14. MOTHER'S MAIDEN NAME <u>Rosie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>217-26-7861</u>	
17. INFORMANT <u>Fort Howard Vet. Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>giving rise to the underlying cause</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>		ADDRESS <u>1407 Eastern Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10358

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DENTIST		25. SIGNATURE OF OTHER	
26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER	
36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER	
56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER	
66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER	
86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER	
96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05359

Reg. Dist. No.

5373

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Manor		c. LENGTH OF STAY in 1b ?	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville Manor		d. STREET ADDRESS 5906 Cecil Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5906 Cecil Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle KANE Last SMITH		4. DATE OF DEATH Month May Day 18 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/15
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Kane Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME May Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 215-34-1337	
17. INFORMANT Mrs. Ruth E. Smith		Address 5906 Cecil Ave. 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive third degree body burns 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ignition of clothes while smoking	
20c. TIME OF INJURY Month, Day, Year 12:30 p. m. 5/18 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21, 59	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Hampden Md. Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd	
24a. REC'D BY REGISTRAR MAY 21 '59		DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5374 CERTIFICATE OF DEATH

05360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RASPBURG</u>		c. LENGTH OF STAY IN 1b <u>2 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>BOX 383 X OLD PHILADELPHIA RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>H.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CEMENT MASON</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLDG TRADES</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>HOWARD H. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>IDA V. WATTS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-6512</u>	
17. INFORMANT <u>EDNA V. SMITH-BOX 383 X OLD PHILA. RD.</u>		Address <u>BALTO. 6 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma - Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 19, 1959</u> to <u>May 14, 1959</u> that I last saw the deceased alive on <u>May 13, 1959</u> , and that death occurred at <u>3:02 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Karl F. Mech, M.D.</u>		DATE SIGNED <u>5/14/59</u>	
PHYSICIAN'S NAME (Type) <u>KARL F. MECH, M.D.</u>		ADDRESS (Street, city or town, state) <u>11 E. Chase Street Balto., Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDAN PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Buchanan 9004 Chestnut St</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1
FOR STATE
HEALTH DEPT.
M
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VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05361

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmont West Mount 67x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 102 Park Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT George SMITH		4. DATE OF DEATH Month Day Year May 12, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1919
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Port Records B.S.D. Rem. Rand		10b. KIND OF BUSINESS OR INDUSTRY Des Moines, Iowa	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archbald Smith		14. MOTHER'S MAIDEN NAME Frankie M. Winterrowd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 11		16. SOCIAL SECURITY NO. 483-07-5907	
17. INFORMANT Mrs. Helen Smith		Address 102 Park Ave. West Mt.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 5/12 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Risen Sun Cemetery		22d. LOCATION (City, town, or county) (State) Des Moines, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. Baltimore, Md.		24a. REC'D BY REGISTRAR MAY 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

5325

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-3-30

NAME OF DECEASED JAMES H. JONES		AGE 35		SEX Male		RACE White		DATE OF DEATH 10-3-30		PLACE OF DEATH Home	
RESIDENCE 1000 N. TOWN ST.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD.		MARRIED Yes		OCCUPATION None	
EDUCATION High School		RELIGION Catholic		MILITARY SERVICE None		PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER J. H. JONES		DATE 10-3-30		PLACE BALTIMORE		STATE MD.		COUNTY BALTIMORE		CITY BALTIMORE	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER OF THE CITY OR COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05362

5376

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2940 Grendon Avenue				d. STREET ADDRESS 2940 Grendon Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sophie Middle Smith Last Smith				4. DATE OF DEATH Month May Day 18 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11, 1875	
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months 4 Days 18 Hours 18 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael Hains				14. MOTHER'S MAIDEN NAME Barbara (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 217-01-57204			
17. INFORMANT Charles M. Doelle				Address 1159 Gorsuch Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Arteriosclerotic Vasc dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Acute Intestinal infection							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1959				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sep 15, 1955 to May 19, 1959 that I last saw the deceased alive on May 15, 1959 and that death occurred at 6:00 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9005 Harford Road, Baltimore DATE SIGNED 5/19/59							
ACTUAL SIGNATURE Frank P. Kasik M.D.							
PHYSICIAN'S NAME (Type) Frank Kasik							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 5-21-59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
22d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue, ZONE 14							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Road				24a. REC'D BY REGISTRAR DATE MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fork		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fork		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fork Rd. Baldwin P.O.				d. STREET ADDRESS Fork Rd. Baldwin P.O.			
3. NAME OF DECEASED (Type or print) William P. Smith First Middle Lost				4. DATE OF DEATH May 15 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24-1893	
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Smith				14. MOTHER'S MAIDEN NAME Myrtle Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-6843		17. INFORMANT Mrs Ruth Smith Fork Ed. Baldwin P.O. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INFARCTION 420.1 DUE TO Hypertensive Cardiovas. Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 1.5 mm 345 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ac. Ileocolitis INTERVAL BETWEEN ONSET AND DEATH #1 8 wks #2 1.5 mm 345							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/27 , 19 59 , to 5/15 , 19 59 , that I last saw the deceased alive on 5/15 , 19 59 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED ACTUAL SIGNATURE Clifford F. Hudson PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-1959		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Family Home 7401 Belair Rd. ADDRESS				24a. REC'D BY REGISTRAR DATE MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kray	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05364

5177 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. LENGTH OF STAY IN 1b 43 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1250 South Rorty-Eighth St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ANDREW Last SMOLKO, Sr.				4. DATE OF DEATH Month May Day 22nd , Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1890	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Tester				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael Smolko				14. MOTHER'S MAIDEN NAME Pauline Tobis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-7667		17. INFORMANT Katherine Y. Smolko		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Parkinsonism DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to May , 19 59 , that I last saw the deceased alive on April , 19 59 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2900 Dunran Road DATE SIGNED Morris Rainess ACTUAL SIGNATURE Morris Rainess M.D. 2900 Dunran Road PHYSICIAN'S NAME (Type) Morris Rainess, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.				24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kross	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05365										
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roadhouse Md</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Baltimore County</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Snowden</u>					4. DATE OF DEATH Month <u>5</u> - Day <u>16</u> Year <u>1959</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1903</u>		9. AGE (In years last birthday) <u>55</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Owings Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Samuel Snowden</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Birch</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-22-0841</u>		17. INFORMANT Address <u>Mrs. Amanda Moore Owings Mills, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>822x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushing of Chest</u> DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Truck overturned on Lyons Mill Road</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>1:55</u> p. m. <u>May 16</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) <u>Owings Mills</u> (County) <u>Balto</u> (State) <u>Md</u>				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>William Upditch</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keisterstown Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Russ</u>					ADDRESS <u>2222 N. North An. Balt. Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>	

2025

5379 CERTIFICATE OF DEATH

05366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 76 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 7103 Heathfield Road (12)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WARREN		First W. Middle SPEDDEN Last		4. DATE OF DEATH May 28 19 59		Day 28 Year 19 59	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1891	
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Office Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Spedden		14. MOTHER'S MAIDEN NAME Della Shakespeare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-03-4830		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE, WITH GENERALIZED METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF RIGHT LOBE OF THYROID							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X attended the deceased from March 13 59 , to May 28 59 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 5/29/59	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-1-59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc.				24a. REC'D BY REGISTRAR North & Pennsylvania Ave Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. Name of Deceased		2. Sex		3. Race	
4. Date of Birth		5. Date of Death		6. Place of Birth	
7. Usual Residence		8. Cause of Death		9. Manner of Death	
10. Physician's Name		11. Hospital or Institution		12. Burial Place	
13. Signature of Physician		14. Signature of Registrar		15. Date of Registration	
16. Name of Informant		17. Relationship to Deceased		18. Informant's Signature	
19. Informant's Address		20. Informant's Telephone		21. Informant's Occupation	
22. Name of Coroner		23. Coroner's Signature		24. Coroner's Seal	
25. Name of Medical Examiner		26. Medical Examiner's Signature		27. Medical Examiner's Seal	
28. Name of Pathologist		29. Pathologist's Signature		30. Pathologist's Seal	
31. Name of Anatomist		32. Anatomist's Signature		33. Anatomist's Seal	
34. Name of Embalmer		35. Embalmer's Signature		36. Embalmer's Seal	
37. Name of Undertaker		38. Undertaker's Signature		39. Undertaker's Seal	
40. Name of Funeral Home		41. Funeral Home's Signature		42. Funeral Home's Seal	
43. Name of Cemetery		44. Cemetery's Signature		45. Cemetery's Seal	
46. Name of Burial Place		47. Burial Place's Signature		48. Burial Place's Seal	
49. Name of Interment		50. Interment's Signature		51. Interment's Seal	
52. Name of Burial		53. Burial's Signature		54. Burial's Seal	
55. Name of Burial		56. Burial's Signature		57. Burial's Seal	
58. Name of Burial		59. Burial's Signature		60. Burial's Seal	
61. Name of Burial		62. Burial's Signature		63. Burial's Seal	
64. Name of Burial		65. Burial's Signature		66. Burial's Seal	
67. Name of Burial		68. Burial's Signature		69. Burial's Seal	
70. Name of Burial		71. Burial's Signature		72. Burial's Seal	
73. Name of Burial		74. Burial's Signature		75. Burial's Seal	
76. Name of Burial		77. Burial's Signature		78. Burial's Seal	
79. Name of Burial		80. Burial's Signature		81. Burial's Seal	
82. Name of Burial		83. Burial's Signature		84. Burial's Seal	
85. Name of Burial		86. Burial's Signature		87. Burial's Seal	
88. Name of Burial		89. Burial's Signature		90. Burial's Seal	
91. Name of Burial		92. Burial's Signature		93. Burial's Seal	
94. Name of Burial		95. Burial's Signature		96. Burial's Seal	
97. Name of Burial		98. Burial's Signature		99. Burial's Seal	
100. Name of Burial		101. Burial's Signature		102. Burial's Seal	

5380 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3 Vol-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edwards Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxburgh Nursing Home</u>		d. STREET ADDRESS <u>4909 Nelson Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Spivack</u> Last <u></u>		4. DATE OF DEATH Month <u>5-</u> Day <u>15-</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Sol</u>	
14. MOTHER'S MAIDEN NAME <u>Ida Fine</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u></u>		INFORMANT <u>Frank Rosen</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X Bronchopneumonia</u> DUE TO (b) <u>Carcinoma of Right Lung</u> DUE TO (c) <u>Cerebral Metastases</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>6 months</u> <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 14, 1959</u> to <u>May 15, 1959</u> that I last saw the deceased alive on <u>May 15, 1959</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cecil Rudner</u> M.D.		ADDRESS (Street, city or town, state) <u>6821 Reisterstown Road, 5/59</u>	
PHYSICIAN'S NAME (Type) <u>CECIL RUDNER MD</u>		DATE SIGNED <u>5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/17/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Herring Open</u>	22d. LOCATION (City, town, or country) (State) <u>Balt MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Galun Place</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1000

3380

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5178 CERTIFICATE OF DEATH

05368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN IB 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1715 Rita Road				d. STREET ADDRESS / 1715 Rita Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE RACHEL EVA SPOHN				4. DATE OF DEATH Month Day Year May 1st, 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8, 1876	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jeremiah Shindel				14. MOTHER'S MAIDEN NAME Anna Baxter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address W.G. Spohn Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SKLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 1956 19... to 5/1/59 , 19... that I last saw the deceased alive on 5/1/59 , 19... and that death occurred at 8:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 33 Dundalk Avenue 5/2/59 ACTUAL SIGNATURE W.E. Baermann, M.D. PHYSICIAN'S NAME (Type) W.E. Baermann, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/59		22c. NAME OF CEMETERY OR CREMATORY Millersville Mennonite		22d. LOCATION (City, town, or county) (State) Millersville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Burke Bradley Dundalk 22				24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5381 CERTIFICATE OF DEATH

Reg. Dist. No. **05369**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 83 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 219 SCHLEY STREET	
3. NAME OF DECEASED (Type or print) First JAMES Middle E Last STAKEM		4. DATE OF DEATH Month MAY Day 10 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-19
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY CHEMICAL COMPANY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS C. STAKEM		14. MOTHER'S MAIDEN NAME ALICE McPARTLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO.	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SOFT TISSUE SARCOMA/WITH LUNG METASTASES 197.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 16, 1959 , to May 10, 1959 , and that death occurred at 9:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald D. Mark		DATE SIGNED 5/11/59	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M. D.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-14-1959	22c. NAME OF CEMETERY OR CREMATORY ST. PETER AND PAUL CEM.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James A. Scarpeley		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	
ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR MAY 14 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

55

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/5B

10331
103310

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...
City of ...

Decedent's Name ...
Age ...

Date of Death ...
Place of Death ...

Signature of ...
Signature of ...

Signature of ...

Signature of ...
Signature of ...

Signature of ...
Signature of ...

5179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1208 WILLOW RD.		d. STREET ADDRESS 1208 WILLOW RD.	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last STEIN		4. DATE OF DEATH MAY 6 1959 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869 OCT. 3, 1869 9. AGE (In years last birthday) 69 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR, PROFESSIONAL		10b. KIND OF BUSINESS OR INDUSTRY BLDG.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NOT KNOWN		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-679048	
17. INFORMANT ALBERT STEIN Address 1208 WILLOW RD (22)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 422.1 DUE TO ARTERIO-SCLEROTIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIO-VASCULAR DISEASE DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 8 DAYS 12 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY a. p. m. _____ b. m. _____ c. y. _____ d. 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from FEB. 12, 1958 , to MAY 6, 1959 , that I last saw the deceased alive on MAY 1, 1959 , and that death occurred at 7:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE. ESSEX 21, MD.	
PHYSICIAN'S NAME (Type) JOSEPH MICELI		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 9, 1959	22c. NAME OF CEMETERY OR CREMATORY LONDON PARK	22d. LOCATION (City, town, or county) (State) BALTO. MD
23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann ADDRESS 3218 HUDSON ST.		24a. REC'D BY REGISTRAR MAY 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05372

5383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 60 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last STITZ				4. DATE OF DEATH Month May Day 4 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 6, 1905	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Stitz				14. MOTHER'S MAIDEN NAME Mamie Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 216-01-0557		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 5, 1959 , to May 4, 1959 , that I last saw the deceased alive and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 5/5/59							
ACTUAL SIGNATURE Donald D. Mark M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kawa	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5384

05373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2600 Block Windsor Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
3. NAME OF DECEASED (Type or print) First BARBARA Middle JEAN Last STOKES		4. DATE OF DEATH Month May Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Roosevelt Hill		14. MOTHER'S MAIDEN NAME Flora Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Flora Hill Address 545 Orchard St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Gunshot Wounds. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation.	
20c. TIME OF INJURY Month, Day, Year 5/8 19 59 Hour 10:00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Parkville (County) Baltimore (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Ann Arundel County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Holstead ADDRESS 918 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE MAY 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

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2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5385

CERTIFICATE OF DEATH

Reg. Dist. No. 05374

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE #4</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(HOLLY HILL MANOR) 531 STEVENSON LANE</u>				d. STREET ADDRESS <u>5806 NORTH WOOD DR.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>VINCENT GILPIN STUBBS</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1869</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>DELTA, PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>V. GILPIN STUBBS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH PIERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>V.G. Stubbs, 5806 Northwood Dr. Balt. 2nd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR D.</u> DUE TO (c) <u>PNEUMONIA RIGHT LOWER LOBE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> <u>YEARS</u> <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MARCH 8, 1958</u> , to <u>MAY 30, 1959</u> , that I last saw the deceased alive on <u>MAY 29, 1959</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7215 YORK Rd. May 30 1959</u>							
ACTUAL SIGNATURE <u>A. Venable Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>S.J. VENABLE, JR. M.D.</u>				<u>BALTIMORE 12 MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-2-1959</u>		<u>Fawn Home Cem.</u>		<u>Fawn Home York Co., Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kenneth W. Dushum, Stewartstown Pa.</u>				24a. REC'D BY REGISTRAR <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

05314

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX MALE		3. AGE 68		4. DATE OF BIRTH 1901		5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION RETIRED		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1925		9. PLACE OF MARRIAGE NEW YORK		10. NAME OF DECEASED'S FATHER JOHN BROWN	
11. NAME OF DECEASED'S MOTHER MARY BROWN		12. DATE OF DEATH 1968		13. PLACE OF DEATH HOME		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL	
16. SIGNATURE OF DECEASED'S PHYSICIAN DR. J. H. SMITH		17. SIGNATURE OF DECEASED'S NEXT OF KIN WILLIAM J. BROWN		18. SIGNATURE OF DECEASED'S MINISTER REV. J. H. SMITH		19. SIGNATURE OF DECEASED'S CHURCH ST. JOHN'S CHURCH		20. SIGNATURE OF DECEASED'S FUNERAL HOME JOHN BROWN	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE FUNERAL HOME AND THE DECEASED'S NEXT OF KIN.

05375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relied upon by the registrar or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK MARYLAND.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7609 Carson Ave.</u>		d. STREET ADDRESS <u>7609 Carson Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>C</u> Last <u>STUMPF, SR</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-99</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IND. ANALYST</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN STUMPF</u>		14. MOTHER'S MAIDEN NAME <u>ANNA OED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-8515</u>	
17. INFORMANT <u>MRS. T-REDA STUMPF</u>		Address <u>7609 Carson Ave. 22</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pyelo-Nephritis</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinson's Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>46</u> , to <u>May 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>59</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>		DATE SIGNED <u>5/29/59</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs</u>		ADDRESS (Street, city or town, state) <u>1010 NORTH Point Rd Baltimore 24 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>		ADDRESS <u>418 Eastern Blvd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 14

THE FINEST BOND

...the ... of ...

CERTIFICATE OF DEATH

Reg. Dist. No. 05376

5387

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakeland, Florida 48X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS Lutherville, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances S. Tarvid		4. DATE OF DEATH Month Day Year May 3 1959	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Lithuania	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Peter Shakimskas		14. MOTHER'S MAIDEN NAME Susan Kaikaris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alexander A. Tarvid,		Address Lakeland, Florida	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerular nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH weeks 3 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April , 19 59 , to May 3 , 19 59 , that I last saw the deceased alive on May 3 , 19 59 , and that death occurred at 11:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1101 N. Calvert St DATE SIGNED 5/7/59 ACTUAL SIGNATURE Ernest C. Brown M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	5-8-59		Lakeland, Florida
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Townson Inc		ADDRESS 1050 York Rd.	
24a. REC'D BY REGISTRAR DATE MAY 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100000

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED ALVIN ...</p>		<p>2. SEX M</p>		<p>3. AGE 35</p>	
<p>4. DATE OF DEATH 10-10-1918</p>		<p>5. PLACE OF DEATH ...</p>		<p>6. CAUSE OF DEATH ...</p>	
<p>7. SIGNATURE OF DECEASED ...</p>		<p>8. SIGNATURE OF WITNESS ...</p>		<p>9. SIGNATURE OF DECEASED ...</p>	
<p>10. SIGNATURE OF DECEASED ...</p>		<p>11. SIGNATURE OF DECEASED ...</p>		<p>12. SIGNATURE OF DECEASED ...</p>	
<p>13. SIGNATURE OF DECEASED ...</p>		<p>14. SIGNATURE OF DECEASED ...</p>		<p>15. SIGNATURE OF DECEASED ...</p>	
<p>16. SIGNATURE OF DECEASED ...</p>		<p>17. SIGNATURE OF DECEASED ...</p>		<p>18. SIGNATURE OF DECEASED ...</p>	
<p>19. SIGNATURE OF DECEASED ...</p>		<p>20. SIGNATURE OF DECEASED ...</p>		<p>21. SIGNATURE OF DECEASED ...</p>	
<p>22. SIGNATURE OF DECEASED ...</p>		<p>23. SIGNATURE OF DECEASED ...</p>		<p>24. SIGNATURE OF DECEASED ...</p>	
<p>25. SIGNATURE OF DECEASED ...</p>		<p>26. SIGNATURE OF DECEASED ...</p>		<p>27. SIGNATURE OF DECEASED ...</p>	
<p>28. SIGNATURE OF DECEASED ...</p>		<p>29. SIGNATURE OF DECEASED ...</p>		<p>30. SIGNATURE OF DECEASED ...</p>	
<p>31. SIGNATURE OF DECEASED ...</p>		<p>32. SIGNATURE OF DECEASED ...</p>		<p>33. SIGNATURE OF DECEASED ...</p>	
<p>34. SIGNATURE OF DECEASED ...</p>		<p>35. SIGNATURE OF DECEASED ...</p>		<p>36. SIGNATURE OF DECEASED ...</p>	
<p>37. SIGNATURE OF DECEASED ...</p>		<p>38. SIGNATURE OF DECEASED ...</p>		<p>39. SIGNATURE OF DECEASED ...</p>	
<p>40. SIGNATURE OF DECEASED ...</p>		<p>41. SIGNATURE OF DECEASED ...</p>		<p>42. SIGNATURE OF DECEASED ...</p>	
<p>43. SIGNATURE OF DECEASED ...</p>		<p>44. SIGNATURE OF DECEASED ...</p>		<p>45. SIGNATURE OF DECEASED ...</p>	
<p>46. SIGNATURE OF DECEASED ...</p>		<p>47. SIGNATURE OF DECEASED ...</p>		<p>48. SIGNATURE OF DECEASED ...</p>	
<p>49. SIGNATURE OF DECEASED ...</p>		<p>50. SIGNATURE OF DECEASED ...</p>		<p>51. SIGNATURE OF DECEASED ...</p>	
<p>52. SIGNATURE OF DECEASED ...</p>		<p>53. SIGNATURE OF DECEASED ...</p>		<p>54. SIGNATURE OF DECEASED ...</p>	
<p>55. SIGNATURE OF DECEASED ...</p>		<p>56. SIGNATURE OF DECEASED ...</p>		<p>57. SIGNATURE OF DECEASED ...</p>	
<p>58. SIGNATURE OF DECEASED ...</p>		<p>59. SIGNATURE OF DECEASED ...</p>		<p>60. SIGNATURE OF DECEASED ...</p>	
<p>61. SIGNATURE OF DECEASED ...</p>		<p>62. SIGNATURE OF DECEASED ...</p>		<p>63. SIGNATURE OF DECEASED ...</p>	
<p>64. SIGNATURE OF DECEASED ...</p>		<p>65. SIGNATURE OF DECEASED ...</p>		<p>66. SIGNATURE OF DECEASED ...</p>	
<p>67. SIGNATURE OF DECEASED ...</p>		<p>68. SIGNATURE OF DECEASED ...</p>		<p>69. SIGNATURE OF DECEASED ...</p>	
<p>70. SIGNATURE OF DECEASED ...</p>		<p>71. SIGNATURE OF DECEASED ...</p>		<p>72. SIGNATURE OF DECEASED ...</p>	
<p>73. SIGNATURE OF DECEASED ...</p>		<p>74. SIGNATURE OF DECEASED ...</p>		<p>75. SIGNATURE OF DECEASED ...</p>	
<p>76. SIGNATURE OF DECEASED ...</p>		<p>77. SIGNATURE OF DECEASED ...</p>		<p>78. SIGNATURE OF DECEASED ...</p>	
<p>79. SIGNATURE OF DECEASED ...</p>		<p>80. SIGNATURE OF DECEASED ...</p>		<p>81. SIGNATURE OF DECEASED ...</p>	
<p>82. SIGNATURE OF DECEASED ...</p>		<p>83. SIGNATURE OF DECEASED ...</p>		<p>84. SIGNATURE OF DECEASED ...</p>	
<p>85. SIGNATURE OF DECEASED ...</p>		<p>86. SIGNATURE OF DECEASED ...</p>		<p>87. SIGNATURE OF DECEASED ...</p>	
<p>88. SIGNATURE OF DECEASED ...</p>		<p>89. SIGNATURE OF DECEASED ...</p>		<p>90. SIGNATURE OF DECEASED ...</p>	
<p>91. SIGNATURE OF DECEASED ...</p>		<p>92. SIGNATURE OF DECEASED ...</p>		<p>93. SIGNATURE OF DECEASED ...</p>	
<p>94. SIGNATURE OF DECEASED ...</p>		<p>95. SIGNATURE OF DECEASED ...</p>		<p>96. SIGNATURE OF DECEASED ...</p>	
<p>97. SIGNATURE OF DECEASED ...</p>		<p>98. SIGNATURE OF DECEASED ...</p>		<p>99. SIGNATURE OF DECEASED ...</p>	
<p>100. SIGNATURE OF DECEASED ...</p>		<p>101. SIGNATURE OF DECEASED ...</p>		<p>102. SIGNATURE OF DECEASED ...</p>	

1

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5388

CERTIFICATE OF DEATH

05377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 03 Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh (4)		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 817 Kingston Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EVA REBECCA TAYLOR		4. DATE OF DEATH Month Day Year May 3, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1880
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lucien Thomas		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Medford Taylor, 817 Kingston Rd., Towson,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Decompensative Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1956 to May 3, 1959 , that I last saw the deceased alive on May 3, 1959 , and that death occurred at 10:40 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Laurence C. Post M.D. 6805 York Rd.		Baltimore 12 Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 6, 1959	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Marvin Williams, Chestertown, Maryland		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5389 CERTIFICATE OF DEATH

05378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater, Maryland 02x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Woodland, Beach	
3. NAME OF DECEASED (Type or print) Kathleen First A. Middle Taylor Last		4. DATE OF DEATH Month May Day 28 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1876
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Ireland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parotitis of left parotid gland			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 59 , to May 28 , 19 59 , that I last saw the deceased alive on May 28 , 19 59 , and that death occurred at 2:30pM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 5-28-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 2, 1959	George Washington	Adelphi Md
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Tallonell		ADDRESS 3603 14th St NW	
24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
B-100 CERTIFICATE OF DEATH

FILE NO. 100

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH MURDER		8. MANNER OF DEATH HOMICIDE		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH April 19, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION None	
13. MARITAL STATUS Single		14. EDUCATION High School		15. RELIGION None	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JURY (None)		21. SIGNATURE OF JUDGE (None)	
22. SIGNATURE OF STATE ATTORNEY (None)		23. SIGNATURE OF DISTRICT ATTORNEY (None)		24. SIGNATURE OF COUNTY CLERK (None)	
25. SIGNATURE OF CITY CLERK (None)		26. SIGNATURE OF TOWN CLERK (None)		27. SIGNATURE OF VILLAGE CLERK (None)	
28. SIGNATURE OF POST OFFICE CLERK (None)		29. SIGNATURE OF RAILROAD CLERK (None)		30. SIGNATURE OF AIRPORT CLERK (None)	
31. SIGNATURE OF MARINE CLERK (None)		32. SIGNATURE OF NAVY CLERK (None)		33. SIGNATURE OF ARMY CLERK (None)	
34. SIGNATURE OF AIR FORCE CLERK (None)		35. SIGNATURE OF SPACE FORCE CLERK (None)		36. SIGNATURE OF OTHER CLERK (None)	

FILE NO. 100

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IS NOT VALID FOR THE PURPOSES OF THE UNITED STATES DEPARTMENT OF HEALTH, WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G242 5-14-59 et

5390

CERTIFICATE OF DEATH

Reg. Dist. No.

05379

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gray Manor				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Oakwood Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle T. TRANSIK Last				4. DATE OF DEATH Month May Day 6 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1889	
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 68 Min.		11. IF UNDER 24 HRS. Months 6 Days 18 Hours 68 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Czechoslovakia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Stanka				14. MOTHER'S MAIDEN NAME Mary Nemshofsky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. Steve Transik 205 Oakwood Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO (b) Coronary insufficiency DUE TO (c) Hypertensive cardio vascular dis. INTERVAL BETWEEN ONSET AND DEATH 2 days 10 + yrs 10 + yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 092x Infectious hepatitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 5/5 , 19 53 , to 5/6 , 19 59 , that I last saw the deceased alive on 5/5 , 19 59 , and that death occurred at 230 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 434 Eastern Ave DATE SIGNED 5/8/59 ACTUAL SIGNATURE J. Platt M.D. PHYSICIAN'S NAME (Type) J. PLATT, M.D. Easy, md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 9, 1959			
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery				22d. LOCATION (City, town, or county) (State) Dundalk, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				24a. REC'D BY REGISTRAR MAY 11 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2005

05380

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>19</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrow Pt.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>719 I. St.</u>		d. STREET ADDRESS <u>1 #1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD WILLIAM TURNER</u>		4. DATE OF DEATH Month Day Year <u>MAY 25 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mill</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Edward Turner</u>		14. MOTHER'S MAIDEN NAME <u>Mary (maiden name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-09-2005</u>	
17. INFORMANT <u>Mamie Turner (wife)</u>		Address <u>address #</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular disease. 5 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paraplegia - 5 years ago</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 18</u> , 19 <u>55</u> , to <u>May 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>59</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tolin</u> M.D.		ADDRESS (Street, city or town, state) <u>6908 N. P. Rd.</u> DATE SIGNED <u>5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Tolin</u>		<u>Balto. 19. Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>5-29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan</u>		ADDRESS <u>Balto. Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>1910-10-15</i></p>	
<p>5. Place of birth: <i>New York City, N.Y.</i></p>		<p>6. Date of death: <i>1955-12-20</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>Dr. J. Smith</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Date of registration: <i>1955-12-25</i></p>		<p>12. Office of registration: <i>Boston, Mass.</i></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

Item 7 Film 6242 5-18-59 et

CERTIFICATE OF DEATH

05381

Reg. Dist. No.

5392

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
c. LENGTH OF STAY IN 1b 2 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 630 N. Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 630 North Arlington Ave. (17)			
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last VAUGHN				4. DATE OF DEATH Month May Day 7 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH March 15, 1907	
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months 7 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing Co. Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John A. Vaughn				14. MOTHER'S MAIDEN NAME Hannah Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-07-7415		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, SQUAMOUS CELL, RIGHT UPPER LOBE OF LUNG, WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X (c) XXXXXX DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5 , 19 59 , to May 7 , 19 59 . I have examined the body of the deceased, and that death occurred at 8:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MD. DATE SIGNED 5/8/59 ACTUAL SIGNATURE John W. Crawford PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Old Field Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5393 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 02X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last WAGNER		4. DATE OF DEATH Month May Day 3 Year 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 8, 1889		9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months 3 Days 19 Hours 59		IF UNDER 24 HRS. Months 3 Days 19 Hours 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Retired	
11. BIRTHPLACE (State or foreign country) Austria Hungary		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jacob Wagner		14. MOTHER'S MAIDEN NAME Judith Schwirian		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 217-05-3428		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 332X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 DAYS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour VA o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from April 24, 1959 , to May 3, 1959 , that I last saw the deceased alive on May 3, 1959 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, FT. HOWARD, MARYLAND		DATE SIGNED 5/4/59		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D., Acting Director, Professional Services		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF May 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Wm. Tiekner & Sons, Inc., North and Penna. Aves., Balto., Md.		24a. REC'D BY REGISTRAR MAY 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05383

5394

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>55</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3 Ridgefield Road</i>		d. STREET ADDRESS <i>3 Ridgefield Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. Philip F. Wagner</i>		4. DATE OF DEATH <i>May 8th 19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 26, 1892</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR: Months <i>66</i> Days <i>66</i> IF UNDER 24 HRS. Hours <i>66</i> Min. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Calvert Dist. Mach.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Margaret Wagner, 3 Ridgefield Road.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Sudden</i> (c) <i>420.1</i> DUE TO cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from? Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>5/9/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/12/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 11 '59</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5395 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PARKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3001 EDGEWOOD AVE</u>				d. STREET ADDRESS <u>13001 EDGEWOOD AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>G WYN</u> Middle <u>WAGONER</u> Last <u></u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28 1897</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEEP HERDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHEEP RANCH</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MONROE WAGONER</u>				14. MOTHER'S MAIDEN NAME <u>FRONNIE CHUDILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		(If yes, give year or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>530-20-3042</u>		17. INFORMANT <u>MRS Molly Simpson</u> Address <u>3001 EDGEWOOD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marasmus</u> <u>163X</u> DUE TO <u>Cancer of the lung</u> Op. Extirpation of the rt lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Cancer</u> (c) <u>Tracheobronchic fenestration</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema pulmonis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>May 15 1959</u> Hour <u>10</u> a.m. <u>15</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>58</u> , to <u>May</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 20</u> 19 <u>59</u> , and that death occurred at <u>0:30 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr John Geldrich</u>				DATE SIGNED <u>M.D. Rose Dale Med. Group 8019 Philad. Rd. BALTO 6, Md.</u>			
PHYSICIAN'S NAME (Type) <u>DR. JOHN GELDRICH</u>				<u>BALTO 6, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAGS MANOR PRESB. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CLIOHORANVILLE PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Henshaw</u>				ADDRESS <u>8802 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1880	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
FEB 10 1920		BALTIMORE, MARYLAND		10:30 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 10 1920		FEB 10 1920		FEB 10 1920		FEB 10 1920	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
FEB 10 1920		FEB 10 1920		FEB 10 1920		FEB 10 1920	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 10 1920		FEB 10 1920		FEB 10 1920		FEB 10 1920	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05385

5396

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5519 Willys Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lorena Louise Walter		4. DATE OF DEATH Month May Day 25 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1886
9. AGE (In years last birthday) yrs. 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Knipp		14. MOTHER'S MAIDEN NAME Catherine Rithmiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212 03 0717	
17. INFORMANT Catherine L. Messerschmidt		Address 5519 Willys Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma to the liver 153.3 DUE TO carcinoma of the sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ Interval between onset and death Unknown Unknown			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Feb. 26, 1959 , to May 25, 1959 , that I last saw the deceased alive on May 24, 1959 , and that death occurred at 8:30 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Bradley Daugharthy, M.D.		ADDRESS (Street, city or town, state) 1264 Francis Ave., Balto. 27, Md.	
PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M.D.		DATE SIGNED May 27, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/28/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	24a. REC'D BY REGISTRAR MAY 28 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Howard H. Hubbard #107 Wilkens Avenue

London Park

Baltimore, Maryland

5/28/59

Death

5519 Willys Avenue

5519 Willys Avenue

Lorena

Louise

Walter

May

25

59

Female

White

X

Dec. 11, 1898

73

Baltimore

U. S. A.

Louis Knipp

Catherine R. Knipp

519 03 071

Catherine L. Messerschmidt

5519 Willys Avenue

5519 Willys Avenue

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

#1/6
05386

5397

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Plainview		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural			d. STREET ADDRESS 18 Spector Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SAM Middle WARREN (WEINSTEIN) Last WARREN (WEINSTEIN)			4. DATE OF DEATH Month May Day 12 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1921		9. AGE (In years at birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Hyam Warren			14. MOTHER'S MAIDEN NAME Sarah (unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Westminster Chapel (F.D) Brooklyn, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Airplane crash					
20c. TIME OF INJURY Hour 5:15 p. m. Month 5/12 Year 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm	
20f. (City or town) Chase		20g. (County) Balto.		20h. (State) Mdd.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/22/59	
EXAMINER'S NAME (Type) M. B. Davis, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-13-59		22c. NAME OF CEMETERY OR CREMATORY Wellwood Cemetery	
22d. LOCATION (City, town, or county) Pinelawn, New York		22e. (State) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street			24a. REC'D BY REGISTRAR MAY 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY
FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit, in any event within 72 hours after death.
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05387

Reg. Dist. No.

5398

1. PLACE OF DEATH a. COUNTY <u>Glen L. Martin Company</u> <u>Baltimore County,</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River, Md., Balto.</u>		c. LENGTH OF STAY IN IB <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen L. Martin Company</u>		d. STREET ADDRESS <u>1325 W. Lafayette Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>James N. Washington</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1932</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painters Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Washington</u>		14. MOTHER'S MAIDEN NAME <u>Louise Bates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1950-52</u>		16. SOCIAL SECURITY NO. <u>215-24-2148</u>	
17. INFORMANT <u>Ruth Washington</u>		Address <u>1325 W. Lafayette Ave</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd + 4th Burns over Entire</u> <u>916.3</u> DUE TO <u>Body</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in Explosion of Airplane Cleaning Fluid</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:40 a.m.</u> <u>5-20-59</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>G.L. Martin Co.</u>	20f. (City or town) (County) (State) <u>Middle River Balto Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		DATE SIGNED <u>5/21/59</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Natl. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>May 22 '59</u>	
ADDRESS <u>716 Penna. Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneass</u>	

03

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me

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05388

5399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. LENGTH OF STAY IN lb <u>63 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DONALD CHARLES WELCH</u>		4. DATE OF DEATH <u>MAY 9 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 10, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>3</u> yrs. <u>29</u> Months <u>3</u> Days <u>29</u> Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LLOYD LEE WELCH</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ANN DULL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CHART - Rosewood School</u>		Address <u>OWINGS MILLS MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of hydrocephalus</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>multiple congenital abnormalities of the</u> DUE TO (c) <u>brain and meningomyelocele</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>since birth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenitally dislocated hips - Mental deficiency - Retal delays</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAR 6, 1959</u> , to <u>MAY 9, 1959</u> , that I last saw the deceased alive on <u>MAY 9, 1959</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Olive Reid Harris MD</u>		ADDRESS (Street, city or town, state) <u>EPST Rosewood State Training School</u> DATE SIGNED <u>MAY 9 1959</u>	
PHYSICIAN'S NAME (Type) <u>OLIVE REID HARRIS MD</u>		<u>OWINGS MILLS MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Lanham Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shewitt J. Waldron</u>		ADDRESS <u>13 Talbot St</u>	
24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2275204XV4

5180 CERTIFICATE OF DEATH

05389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. LENGTH OF STAY IN TB 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1772 Melbourne Road				d. STREET ADDRESS 1772 Melbourne Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RAYMOND Middle CARL Last WERNECKE				4. DATE OF DEATH Month May Day 3rd Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1907	
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsmen				10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Herman C. Wernecke				14. MOTHER'S MAIDEN NAME Charlotte Rehbein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 392-03-7344		17. INFORMANT Thomas L. Wernecke Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Transverse Colon - 2-12-59 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-1 , 1958 , to 5-3 , 1959 , that I last saw the deceased alive on 5-3 , 1959 , and that death occurred at 1:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Morningson Road DATE SIGNED Eugene F. Navy							
ACTUAL SIGNATURE Eugene F. Navy M.D.				Baltimore 22, Maryland			
PHYSICIAN'S NAME (Type) Eugene Navy, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/59		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Manitowoc, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. ADDRESS Dundalk 22				24a. REC'D BY REGISTRAR DATE MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05390

5400

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Michigan c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grand Rapids 59X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS 144 Benjamin S.E.			
3. NAME OF DECEASED (Type or print) First SUE Middle ANN Last WESSELL				4. DATE OF DEATH Month May Day 12 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1938		9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess		10b. KIND OF BUSINESS OR INDUSTRY Airplane		11. BIRTHPLACE (State or foreign country) Mich.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter Wessell				14. MOTHER'S MAIDEN NAME Lucille Ludwig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO.		17. INFORMANT Address Johnkoff Funeral Home—Grand Rapids, Mich.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash					
20c. TIME OF INJURY Month, Day, Year 5:15 5/12 19 59 Hour 5:15 P. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air over farm		20f. (City or town) (County) (State) Chase Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles F O'Donnell</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Grand Rapids, Mich.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner & Sons - Balto</i>				24a. REC'D BY REGISTRAR 17		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Deputy Medical Examiner. To execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5401

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Balto. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 941 Masfield Road		d. STREET ADDRESS 941 Masfield Road	
3. NAME OF DECEASED (Type or print) First Cecelia A. Middle West Last		4. DATE OF DEATH Month May Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1879
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael O'Mara		14. MOTHER'S MAIDEN NAME Elizabeth Schallenberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mrs. Elizabeth Grauer, 941 Masfield Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 447X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular disease (c) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1956 to May 30, 1959 and that death occurred at 2 PM from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 11 E. Chase Baltimore 2	
ACTUAL SIGNATURE Christian S. Mass, M.D.		DATE SIGNED 11 E. Chase Baltimore 2	
PHYSICIAN'S NAME (Type) Christian S. Mass, M.D.		11 E. Chase St, Baltimore 2, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 2/59	22c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05333

2407

Salts

Maryland

Baltimore

Catonsville

Catonsville

x

951 Waverly Road

951 Waverly Road

12/30/59

West

Cecilia A. West

30

North 3, 1973

x

White

Female

USA

Salts, MD.

Salts, MD.

H.W.

Elizabeth Schaeferberger

Michael C. Marx

Mrs. Elizabeth Schaeferberger, 951 Waverly Rd.

Baltimore, Md.

Post Office

Attacks P.O. Box 1000000 Ave

CERTIFICATE OF DEATH

Reg. Dist. No.

05392

1. PLACE OF DEATH **Rosewood State Training School**
o. COUNTY **Baltimore** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **City**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills, Maryland

c. LENGTH OF STAY IN 1b
1 year

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓
Baltimore 13, Maryland **3V01-4**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rosewood State Training School

d. STREET ADDRESS
1516 East Preston Street

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Wilmore**Jr.****White**

4. DATE OF DEATH

Month

Day

Year

5**28****19 59**

5. SEX

Male

6. COLOR OR RACE

Negro7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/16/57

9. AGE (In years lost birthday) yrs.

12

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wilmore White, Sr.

14. MOTHER'S MAIDEN NAME

Sarah B. Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

INFORMANT

Address

Rosewood Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)**351X**

DUE TO

Pneumonia, right lung

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

Quadriplegia with symptomatic epilepsy

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Cerebral defect etiology undetermined19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
1920d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:15 a.m.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Peter W. Rieckert Pathologist M.D.**5/28/59**

PHYSICIAN'S NAME (Type)

Peter W. Rieckert**4307 Mainfield Ave. Baltimore 14**

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Funeral 5-29-59 Arbutus MEM. Park Arbutus, Md.**JUN 3 '59****Arthur S. Kraus**

1
2

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1522

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5403

CERTIFICATE OF DEATH

05393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 years 6 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>W.</u> Last <u>Whitney</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12- 27- 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beauty Shop operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion HAMILTON</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT (daughter) <u>Mrs. Marian Benson</u>		Address <u>6600 Altamount Ave. Balto. 28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> <u>several years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 21, 19 55</u> to <u>May 31, 19 59</u> , that I last saw the deceased alive on <u>May 31, 19 59</u> , and that death occurred at <u>12:05P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp. Catonsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M.D.</u>		DATE SIGNED <u>5/31/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall & Son</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 243 6-8-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05394

5404

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn c. LENGTH OF STAY IN 1b Woodlawn d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5100 Oaklawn Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 5100 Oaklawn Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA M. WIENCKE		4. DATE OF DEATH Month May Day 31 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 Jan. 7, 1886
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Feick		14. MOTHER'S MAIDEN NAME Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lillian Boland-5100 Oaklawn Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old age DUE TO Carcinoma of colon (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH about 2 Yrs about 3 mo.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore,		20f. (City or town) (County) (State) Md.	
21. I certify that I attended the deceased from January 10, 1957 to May 31, 1959 , that I last saw the deceased alive on May 30, 1959 , and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 516 Cathedral St., Baltimore 1, Md. DATE SIGNED 6/1/59 ACTUAL SIGNATURE Ernest G. Marr M.D. PHYSICIAN'S NAME (Type) Ernest G. Marr, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR JUN 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

405

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1945		10:30 AM		Home		Dr. J. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	

5405 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>O. Wilkinson</u> Middle <u>O.</u> Last		4. DATE OF DEATH <u>May</u> Month <u>18</u> Day <u>1959</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>25 JULY 1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Florist</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO Md</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>OLANDER WILKINSON</u>	
14. MOTHER'S MAIDEN NAME <u>GENA C. HELFRICH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>219-76-4138</u>		17. INFORMANT <u>GENA C. HOLDEN</u> Address <u>1610 E. 78th St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary insufficiency</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>18 May, 1959</u> to <u>18 May, 1959</u> , that I last saw the deceased alive on <u>18 May, 1959</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>James E. Rowe</u> M.D.		PHYSICIAN'S NAME (Type) <u>James E. Rowe, Jr. M.D.</u> <u>715 Frederick Rd. Catonsville #28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	22b. DATE THEREOF <u>27 MAY 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HERMAN PARK CEM</u>	22d. LOCATION (City, town, or county) (State) <u>WOODLAWN Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. M. Walters</u> ADDRESS <u>Pratt St</u>		24a. REC'D BY REGISTRAR <u>May 22 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05396

Reg. Dist. No.

5406

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. LENGTH OF STAY IN 1b 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Duncan Hill Rd.				d. STREET ADDRESS Duncan Hill Rd.			
3. NAME OF DECEASED (Type or print) James Earl Williams				4. DATE OF DEATH Month May Day 16 Year 1959			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31/98		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Williams				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217 01 3055		17. INFORMANT Myrtle Jackson Sparks, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio vascular disease. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE A. M. France				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) A.M. France				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/19/59		22c. NAME OF CEMETERY OR CREMATORY Stephenson		22d. LOCATION (City, town, or county) (State) Sparks, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Chatman Jr.				24a. REC'D BY REGISTRAR DATE MAY 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. France	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 16 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 2212-2	
3. NAME OF DECEASED (Type or print) First PAUL Middle O. Last WILLIAMS		4. DATE OF DEATH Month May Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 21, 1903
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Eldorado, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clayton Williams		14. MOTHER'S MAIDEN NAME Levinia Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 213-14-6927	
17. INFORMANT Mrs. Lavinia Williams (Wife) Sal. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA SEVERE 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EMPHYSEMA OBSTRUCTIVE TYPE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS FAR ADVANCED ACTIVE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11, 1959 to May 27, 1959 , that I last saw the deceased on May 27, 1959 , and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 5/27/59 ACTUAL SIGNATURE John W. Crawford PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M. D. VAH, Fort Howard, Maryland 5/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF BURIAL, CREMATION, OR REMOVAL May 31 59	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

100-100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Name of Deceased		Date of Death		Place of Death	
John Doe		May 15, 1968		Baltimore, Maryland	
Age		Sex		Race	
45		Male		White	
Marital Status		Occupation		Cause of Death	
Married		Teacher		Heart Disease	
Date of Birth		Date of Death		Time of Death	
Jan 1, 1923		May 15, 1968		10:30 AM	
Place of Birth		Place of Death		Signature of Physician	
Baltimore, Maryland		Baltimore, Maryland		[Signature]	
Signature of Registrar		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

DEPARTMENT OF HEALTH - BALTIMORE, MD

5408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 W. Seminary Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anne Elizabeth Wilson		4. DATE OF DEATH Month 5 Day 8 Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873 10-1-1878
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Schofield		14. MOTHER'S MAIDEN NAME ?????	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT O.W. Buck		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - Decompensative 450x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10 19 59 , to May 8 19 59 , that I last saw the deceased alive on May 8 19 59 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6905 York Rd Baltimore 12 Md DATE SIGNED 5/9/59			
ACTUAL SIGNATURE Laurence C. Post		M.D. Laurence C. Post	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		Baltimore 12 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-9-59	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill	22d. LOCATION (City, town, or county) (State) XTowson 4, Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		ADDRESS 622 York Rd., Towson 4, Md.	
24a. REC'D BY REGISTRAR DATE MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

1908

Baltimore Maryland

Lutherville life

208 W. Seminary Ave. 208 W. Seminary Ave.

1-3-55

Anne Elizabeth Wilson

female white 10-1-1877

housewife home England

Joseph Schofield

no none above

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

2-9-55 Prospect Hill Ytwood H. Co.


622 York St., Towson, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 5181 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7300 Dunman Way				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk d. STREET ADDRESS 6808 Holabird Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle Lawrence Last WINES				4. DATE OF DEATH Month May Day 20 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-8-1904		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10b. KIND OF BUSINESS OR INDUSTRY Nat. Gypsum Co.		11. BIRTHPLACE (State or foreign country) Parkersburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Wines				14. MOTHER'S MAIDEN NAME Anna ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-09-2848		17. INFORMANT Address Mrs. Dora E. Wines, 6808 Holabird Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Fossa Dural Tumor. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				5/20/59	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/59		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE MAY 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05400

5409 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr2mth6dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown 18 x - 2	
f. STREET ADDRESS Leonardtown, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Mattingly Last Wise		4. DATE OF DEATH Month May Day 12 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Mattingly		14. MOTHER'S MAIDEN NAME Hortense Hayden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 30, 19 59 , to May 12, 19 59 , that I last saw the deceased alive on May 12, 19 59 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-12-59	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/15/59	22c. NAME OF CEMETERY OR CREMATORY St. Aloysius	22d. LOCATION (City, town, or county) (State) Leonardtown Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Clarke Mattingly		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF JUDGE</p>	
<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>		<p>23. SIGNATURE OF CITY CLERK</p>		<p>24. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>25. SIGNATURE OF VILLAGE CLERK</p>		<p>26. SIGNATURE OF POST OFFICE CLERK</p>		<p>27. SIGNATURE OF SCHOOL CLERK</p>		<p>28. SIGNATURE OF CHURCH CLERK</p>	
<p>29. SIGNATURE OF MINISTRY CLERK</p>		<p>30. SIGNATURE OF CONGREGATION CLERK</p>		<p>31. SIGNATURE OF SYNOD CLERK</p>		<p>32. SIGNATURE OF CONFERENCE CLERK</p>	
<p>33. SIGNATURE OF ANNUAL MEETING CLERK</p>		<p>34. SIGNATURE OF GENERAL ASSEMBLY CLERK</p>		<p>35. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>36. SIGNATURE OF JUDICIAL CLERK</p>	
<p>37. SIGNATURE OF EXECUTIVE CLERK</p>		<p>38. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>39. SIGNATURE OF JUDICIAL CLERK</p>		<p>40. SIGNATURE OF EXECUTIVE CLERK</p>	
<p>41. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>42. SIGNATURE OF JUDICIAL CLERK</p>		<p>43. SIGNATURE OF EXECUTIVE CLERK</p>		<p>44. SIGNATURE OF LEGISLATIVE CLERK</p>	
<p>45. SIGNATURE OF JUDICIAL CLERK</p>		<p>46. SIGNATURE OF EXECUTIVE CLERK</p>		<p>47. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>48. SIGNATURE OF JUDICIAL CLERK</p>	
<p>49. SIGNATURE OF EXECUTIVE CLERK</p>		<p>50. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>51. SIGNATURE OF JUDICIAL CLERK</p>		<p>52. SIGNATURE OF EXECUTIVE CLERK</p>	
<p>53. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>54. SIGNATURE OF JUDICIAL CLERK</p>		<p>55. SIGNATURE OF EXECUTIVE CLERK</p>		<p>56. SIGNATURE OF LEGISLATIVE CLERK</p>	
<p>57. SIGNATURE OF JUDICIAL CLERK</p>		<p>58. SIGNATURE OF EXECUTIVE CLERK</p>		<p>59. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>60. SIGNATURE OF JUDICIAL CLERK</p>	
<p>61. SIGNATURE OF EXECUTIVE CLERK</p>		<p>62. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>63. SIGNATURE OF JUDICIAL CLERK</p>		<p>64. SIGNATURE OF EXECUTIVE CLERK</p>	
<p>65. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>66. SIGNATURE OF JUDICIAL CLERK</p>		<p>67. SIGNATURE OF EXECUTIVE CLERK</p>		<p>68. SIGNATURE OF LEGISLATIVE CLERK</p>	
<p>69. SIGNATURE OF JUDICIAL CLERK</p>		<p>70. SIGNATURE OF EXECUTIVE CLERK</p>		<p>71. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>72. SIGNATURE OF JUDICIAL CLERK</p>	
<p>73. SIGNATURE OF EXECUTIVE CLERK</p>		<p>74. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>75. SIGNATURE OF JUDICIAL CLERK</p>		<p>76. SIGNATURE OF EXECUTIVE CLERK</p>	
<p>77. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>78. SIGNATURE OF JUDICIAL CLERK</p>		<p>79. SIGNATURE OF EXECUTIVE CLERK</p>		<p>80. SIGNATURE OF LEGISLATIVE CLERK</p>	
<p>81. SIGNATURE OF JUDICIAL CLERK</p>		<p>82. SIGNATURE OF EXECUTIVE CLERK</p>		<p>83. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>84. SIGNATURE OF JUDICIAL CLERK</p>	
<p>85. SIGNATURE OF EXECUTIVE CLERK</p>		<p>86. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>87. SIGNATURE OF JUDICIAL CLERK</p>		<p>88. SIGNATURE OF EXECUTIVE CLERK</p>	
<p>89. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>90. SIGNATURE OF JUDICIAL CLERK</p>		<p>91. SIGNATURE OF EXECUTIVE CLERK</p>		<p>92. SIGNATURE OF LEGISLATIVE CLERK</p>	
<p>93. SIGNATURE OF JUDICIAL CLERK</p>		<p>94. SIGNATURE OF EXECUTIVE CLERK</p>		<p>95. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>96. SIGNATURE OF JUDICIAL CLERK</p>	
<p>97. SIGNATURE OF EXECUTIVE CLERK</p>		<p>98. SIGNATURE OF LEGISLATIVE CLERK</p>		<p>99. SIGNATURE OF JUDICIAL CLERK</p>		<p>100. SIGNATURE OF EXECUTIVE CLERK</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5410 CERTIFICATE OF DEATH

Reg. Dist. No.

05401

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest Cleveland Witt		4. DATE OF DEATH May 11, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10b. KIND OF BUSINESS OR INDUSTRY Davidson Chem.	
11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Annie E. Ruhling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215 07 7709	
17. INFORMANT Myrtle E. Witt		Address 3901 Coolidge Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arterio Sclerosis (c) Blind - Sudden		INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 2-27-59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-29, 1955 , to 5-11, 1959 , that I last saw the deceased alive on 5-10, 1959 , and that death occurred at 11 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James Stowace M.D.		ADDRESS (Street, city or town, state) Catonsville	
PHYSICIAN'S NAME (Type)		DATE SIGNED 5-11	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/14/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR MAY 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1911

Baltimore

Maryland

Baltimore

Baltimore

XX

3901 Coolidge Avenue

House in the Pines

59

May 11,

Cleveland, Ohio

First

Dec. 18, 1895

male white

U. S. A.

Davidson Chem. Laboratory, Virginia

Machine

Annie E. Robinson

Unknown

215 07 7709 Myrtle E. West 3901 Coolidge Avenue

no

Baltimore, Maryland

Mc. Oliver

5/14/59

Howard H. Hubbard 4107 Wilkins Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05402

5411 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6710 Beech Ave.		d. STREET ADDRESS 6710 Beech Ave.	
3. NAME OF DECEASED (Type or print) Margaret B. Wohrna		4. DATE OF DEATH Month May Day 5 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Schein		14. MOTHER'S MAIDEN NAME Charlotte Benner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles J. Wohrna		Address 6710 Beech Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-27- 1959 , to 5-5- 1959 , that I last saw the deceased alive on 4-27- 1959 , and that death occurred at 9 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 W. Overlea Ave. Baltimore, 6, Md. DATE SIGNED 5-6-59			
ACTUAL SIGNATURE Dr. Richard R. Rigler		M.D. Baltimore, 6, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Larsen Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

RECORDED
INDEXED

FILED IN 100-100000-100000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05403

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nicodemus Rd.		d. STREET ADDRESS Cedamere Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle D. Last Wolf		4. DATE OF DEATH Month May Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cattle Dealer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob W. Wolf		14. MOTHER'S MAIDEN NAME Sarah A. Kreidler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-4548	
17. INFORMANT Mrs. Louise B. Wolf		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 981x (c) 981x DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:30 5/11 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 5/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05404

Reg. Dist. No.

5413

1
FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. LENGTH OF STAY IN 1b 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Sparks	
3. NAME OF DECEASED (Type or print) First Irvin Middle Clarence Last Woodward		4. DATE OF DEATH Month May Day 26 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1897
9. AGE (In years) 61 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY tool mfg.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm. D. Woodward	
14. MOTHER'S MAIDEN NAME Lydia Christ		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-07-6262		17. INFORMANT Lillian W. Woodward Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 154x DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of the rectum with metastases. (c) 154x DUE TO gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A.M. France		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) A.M. France		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-59	
22c. NAME OF CEMETERY OR CREMATORY Dul. Valley Mem. Gardens		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05405

5414 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18yr8mth22dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Zack		4. DATE OF DEATH Month May Day 19 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
16. SOCIAL SECURITY NO. Unknown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 14, 1959 , to May 19, 1959 , that I last saw the deceased alive on May 19, 1959 , and that death occurred at 5:25a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 5-19-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 23/59	Sacred Heart of Mary	Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozagowski		24a. REC'D BY REGISTRAR 1930 Eastern	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

5415 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL KINGSVILLE		c. LENGTH OF STAY IN 1b 39YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RTH 1 BOX 111 STOCKSDALE RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WESLEY MICHAEL ZAIKO		4. DATE OF DEATH Month Day Year MAY 13 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 16 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? 1ST PAPER.	
13. FATHER'S NAME MICHAEL ZAIKO		14. MOTHER'S MAIDEN NAME NASTOKA UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 25182565	
17. INFORMANT AGAFIA ZAIKO		Address STOCKSDALE RD KINGSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/20 , 19 64 , to 5/13 , 19 59 , that I last saw the deceased alive on 5/13 , 19 59 , and that death occurred at 3:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson Fork MD.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON FORK MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 16 1959	22c. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEM	22d. LOCATION (City, town, or county) (State) ELKRIDGE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Duffel Baw		ADDRESS 1800 E LOMBARD ST.	
24a. REC'D BY REGISTRAR MAY 18 '59		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5416

CERTIFICATE OF DEATH

05407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 601 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY First ZALOSKI Middle LAST		4. DATE OF DEATH Month May Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1869
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Margaret Busse		Address 601 Maryland Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DUE TO (c) DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERE HYPOCHROMIC ANAEMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 6, 1957 , to MAY 24, 1959 , that I last saw the deceased alive on MAY 23, 1959 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE	
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.		DATE SIGNED 5/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 1901 Eastern Avenue	
24a. REC'D BY REGISTRAR MAY 26 1959		24b. REGISTRAR'S SIGNATURE Arthur L. Thompson	

CERTIFICATE OF DEATH

MINISTERS STATE DEPARTMENT OF HEALTH - BATHING 10

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